CIVIL DISTRICT COURT
PARISH OF ORLEANS
STATE OF LOUISIANA

GLORIA SCOTT AND DEANIA JACKSON	*	NO. 96-8461
VERSUS	*	DIVISION "K"
THE AMERICAN TOBACCO COMPANY, INC., ET AL.	*	DOCKET NO. 4

* * * * * * * *

VOLUME II

Continuation of the videotaped deposition of HUGH W. LONG, Ph.D., Department of Health Systems Management and Institute for Health Services Medicine, Suite 1900, 1440 Canal Street, New Orleans, Louisiana 70112, taken in the Law offices of Adams and Reese, L.L.P., Suite 4500, One Shell Square, 701 Poydras Street, New Orleans, Louisiana 70139, commencing at 1:32 o'clock p.m., on Tuesday, the 17th day of April, 2001.

APPEARANCES:

BRUNO AND BRUNO
Attorneys at Law
(By: Joseph M. Bruno, Esquire)
825 Baronne Street
New Orleans, Louisiana 70113
(Attorneys for the Plaintiffs)

ADAMS AND REESE, L.L.P.
Attorneys at Law
(By: Martin A. Stern, Esquire
Ann R. Koppel, Esquire)
Suite 4500, One Shell Square
701 Poydras Street
New Orleans, Louisiana 70139
(Attorneys for the Defendant,
Philip Morris, Incorporated)

VIDEOTAPED BY:

John B. Lanford
Evidence Management, L.L.C.

REPORTED BY:

CHERYL FOURNET HUFFMAN, RMR, CRR
Registered Merit Reporter
Certified Realtime Reporter
(No. 75009)
Huffman & Robinson, Inc.
One Shell Square, Suite 250 Annex
New Orleans, Louisiana 70139
(504) 525-1753 (800) 749-1753

* * * * *

I N D E X

EXHIBITS

* * * * *

S T I P U L A T I O N

It is stipulated and agreed by and among counsel for the parties hereto that the deposition of the aforementioned witness is hereby being taken under the Louisiana Code of Civil Procedure, Article 1421, et seq., for all purposes, in accordance with law;

That the formalities of reading and signing are specifically not waived;

That the formalities of filing, sealing, and certification are specifically waived;

That all objections are reserved until trial or other use of the deposition, except those objections regarding the form of the question or the existence of a privilege.

* * * * *

CHERYL FOURNET HUFFMAN, Registered Merit Reporter, in and for the Parish of Orleans, State of Louisiana, officiated in administering the oath to the witness.

HUGH W. LONG, Ph.D.,

after having been first duly sworn by the above-mentioned Registered Merit Reporter, did testify as follows:

EXAMINATION BY MR. BRUNO:

Q. Good afternoon, Doctor. Joe Bruno again. It's been some time since you and I visited.

(Whereupon a discussion was held off the record.)

THE VIDEOGRAPHER:

Today is April 17th, 2001. This is the videotaped deposition of Dr. Hugh W. Long. We are going on the record at 1:32 p.m. I am John Lanford of Evidence Management, L.L.C.

Now counsel will please notice their appearance off camera and then the court reporter will swear in the witness.

MR. BRUNO:

Joe Bruno for the class.

MR. STERN:

And Martin Stern for Philip Morris.

MR. BRUNO:

And do you want to swear him again?

THE COURT REPORTER:

You're still under oath, Doctor, if I can remind you.

MR. BRUNO:

We could triple swear you now. I mean, now I know I got you good.

EXAMINATION BY MR. BRUNO:

Q. As I said, Doctor, it's been many, many, many months. Would you please tell me what, if anything, you have done since your appearance at the last deposition for which you have billed these tobacco lawyers or -- at their request?

A. I have continued to work on the matter and, in particular, have reviewed the deposition transcripts of -- from Dr. Burns; I have -- excuse me -- I have reviewed a series of, I guess they would classify as pleadings, various motions from both sides and responses to motions; I have prepared an affidavit; I have prepared an additional analysis of costs of the proposed monitoring program; and done the background research associated with that work.

MR. BRUNO:

Okay. Martin, have you supplied us with all the new materials he's looked at? I know that you've given me this FAX dated April 5. But I guess I need -- I don't need you to give me the depo transcripts; but if you would identify the depo transcripts, that would be helpful. And the pleadings, I don't need to see them, just identify them for me, please.

MR. STERN:

I will be happy to do that. From memory, the deposition transcripts were all three days of Dr. Burns' deposition.

MR. BRUNO:

Up till completion?

MR. STERN:

Through completion.

MR. BRUNO:

All right. So I just want to make it -- We agree then that you have seen the entirety of Dr. Burns' deposition.

THE WITNESS:

That is what's been represented to me. Three volumes.

MR. BRUNO:

That's fair. And we can leave it at that, Martin.

THE WITNESS:

Okay.

MR. BRUNO:

Okay. The pleadings?

MR. STERN:

All the Daubert pleadings on Dr. Burns and Dr. Long.

MR. BRUNO:

Okay. The ones you filed and the ones we filed?

MR. STERN:

Correct.

MR. BRUNO:

Okay. Fair enough.

How about the ones on Rosen and Harrison?

MR. STERN:

I don't think so. Although I think that Dr. Long may have been provided the Court's order on Drs. Rosen and Harrison.

MR. BRUNO:

All right. And how about the affidavit?

MR. STERN:

Of who?

MR. BRUNO:

That he prepared.

MR. STERN:

That's an attachment that you have to the motion, the Daubert motion that defense filed against Dr. Burns.

MR. BRUNO:

Okay. Good. All right. And then I guess let me show you --

THE WITNESS:

Let me supplement it.

MR. BRUNO:

Of course.

THE WITNESS:

There is one other deposition that I received, which was the deposition of Dr. Culbertson. And I also received a copy of a report of Dr. Wecker.

MR. BRUNO:

Dr. who?

THE WITNESS:

Wecker.

MR. STERN:

Wecker.

THE WITNESS:

W-E-C-K-E-R, I believe.

MR. BRUNO:

You'll have to help me. That's a new one on me. Have you got that one?

MR. STERN:

Wecker is the defense expert statistician, I believe, by training.

MR. BRUNO:

Is that a new one?

MR. STERN:

No. It was filed back at the original deadline.

MR. BRUNO:

We have your -- We haven't deposed him.

MR. STERN:

You have deposed him.

MR. BRUNO:

We have?

MR. STERN:

Danny Becnel took his deposition.

MR. BRUNO:

In that case, I'm sure he was sliced

up like --

MR. STERN:

And Dr. Wecker has also submitted an affidavit in support of the Daubert motion filed with respect to Dr. Burns.

MR. BRUNO:

Okay.

EXAMINATION BY MR. BRUNO:

Q. All right. Let me show you this letter with attachments, Dr. Long. And then, if you would, identify the attachments as being the so-called additional analysis?

A. (Witness reviews document.) Yes, the letter is a letter to Mr. Redfearn from Mr. Stern, which is Mr. Stern's --

Q. Work product?

A. -- work product.

Q. And attached to it?

A. (Witness reviews document.) I am trying to remember if this last page is complete.

Q. Well, why don't you check your files and we'll see?

A. Well, I don't have any files with me.

Q. Well, those were subpoenaed, so they should be here.
A. I have not received a subpoena in conjunction with today.
Q. You have your original subpoena from the first day. This is a continuation. Nothing has changed.
A. Well, it --
MR. STERN:
He produced that the first day.
THE WITNESS:
It may be that --
MR. BRUNO:
No, he didn't produce this the first day. This is your supplement.
MR. STERN:
Well, we produced this to you in advance of this deposition.
MR. BRUNO:
And he can't tell me whether or not it's complete. Give me a break.
MR. STERN:
Well, can I see it?
THE WITNESS:
I'm not sure --

MR. BRUNO:

How can you tell him --

THE WITNESS:

-- whether there was an additional page was FAXed or not that may have had one additional reference on it.

MR. STERN:

There can't be any confusion here, Joe, because you got this attached to a pleading.

MR. BRUNO:

No, I didn't. I got this attached to your letter.

MR. STERN:

You also got it attached to a pleading, which is what I'm looking at, which is the Defendants' Memorandum in Opposition -- I'm sorry -- Defendants' Memorandum in Support of Motion to Exclude Inadmissible Opinion Testimony of Dr. David Burns.

MR. BRUNO:

All right. Well, why don't you show that to the witness and he can verify whether it's complete?

MR. STERN:

I'd be happy to.

No, I stand corrected. This wasn't attached to that pleading. But why don't you go on and I'll be happy to see if I can get a copy.

MR. BRUNO:

That would be very helpful.

THE WITNESS:

Right.

MR. BRUNO:

I just want to make sure I've got everything that --

THE WITNESS:

Right.

MR. BRUNO:

Because this came last week.

THE WITNESS:

We did provide an original copy.

MR. BRUNO:

I'm sure you did to Martin, there's no question about that. I just want to make sure that I've got the whole thing so that we can proceed.

Now, --

MR. STERN:

Okay. Joe, I can tell you right now, if you'd like.

MR. BRUNO:

Sure.

MR. STERN:

And I think you are missing a page. I think somebody left your last page off. The document that you have, Joe, is the same as "Exhibit 4" attached to Defendants' Memorandum in Opposition to Plaintiffs' Motion to Exclude the Testimony of Hugh Long, Ph.D.

MR. BRUNO:

All right.

MR. STERN:

And --

MR. BRUNO:

All right. Well, just so you'll know, Martin, I have in front of me a FAX from Adams and Reese which indicates 20 pages. And the last page is 19, so I must be missing one page.

MR. STERN:

Well, if it's our mistake, I

apologize.

MR. BRUNO:

No big deal. Just --

MR. STERN:

But this is the same --

MR. BRUNO:

Can we use that as an exhibit?

MR. STERN:

Sure.

MR. BRUNO:

All right. That probably is the easiest and safest way to resolve the problem. I'm going to mark this thing in globo as "Long Number 3."

(Whereupon the document as described above was marked as "Long Exhibit Number 3.")

MR. BRUNO:

Okay. Are you comfortable now, Doctor, that we've got a complete set?

THE WITNESS:

Let me look at this one.

MR. BRUNO:

Take your time.

You know, that's the one problem

with FAXing is you never know if you got a complete set or not.

THE WITNESS:

(Reviews document.)

MR. STERN:

Do you have an extra copy of that, Joe, less obviously the last page?

MR. BRUNO:

Yes.

MR. STERN:

Can I use this one?

MR. BRUNO:

Sure, you can.

MR. STERN:

Okay. Thank you.

MR. BRUNO:

That's my FAX. I'm not ready to go into that, anyway, Martin, if you want to send it out for copying.

MR. STERN:

Okay.

THE WITNESS:

Yes, sir, this appears to be complete.

EXAMINATION BY MR. BRUNO:

Q. Okay. Great.
All right. Now, at your last deposition, you recall that you told me that you were not able to provide me with an opinion relative to Dr. Burns' -- and I'm going to, for the lack of a better description, I'm just going to call them the numbers, okay? The attachments to his report. Because you didn't understand the source of the numbers. Do you remember that? Do you remember telling me that?
A. Yes, with -- Are we talking about Dr. Burns' spreadsheets?
Q. Yes.
A. Yes, I remember indicating that for the vast majority of the numbers in that spreadsheet, I did not have sources or authorities either in his report or in the spreadsheets themselves.
Q. Okay. All right. Now, --
MR. STERN:
Excuse me, Joe. What did you label that exhibit just so I can --
MR. BRUNO:
"Number 3."

MR. STERN:

Okay.

MR. BRUNO:

Because we have, apparently, I'm told, two exhibits from the first deposition.

MR. STERN:

Okay.

MR. BRUNO:

All right?

EXAMINATION BY MR. BRUNO:

Q. Now, have you had a chance to review the definition of this class?

A. I have reviewed the definition of the class.

Q. All right. And you understand that the cessation program is for former smokers or smokers who desire assistance in stopping smoking?

MR. STERN:

Let me object to the form. I don't know what that has to do with the class definition.

MR. BRUNO:

That's what the definition says.

MR. STERN:

Well, the class definition is a definition of the class.

MR. BRUNO:

Right.

MR. STERN:

For all purposes.

MR. BRUNO:

Okay. And your question -- So what's your point?

MR. STERN:

You seem to be making a connection to the cessation program that I don't think is a part of the class definition, but --

MR. BRUNO:

Well, it is.

EXAMINATION BY MR. BRUNO:

Q. Well, then, you tell me what's your understanding of the class as it relates to cessation then.

A. Well, the class is defined with respect to both cessation and monitoring, as I appreciate it.

Q. Right. So let's --

A. Not just for one or --

Q. No, I understand.

So with regard to the cessation component, what is your understanding of the Court's definition of the class as it relates to the remedy of cessation?

A. The same as it is for monitoring.

Q. Which is what?

A. Which is current -- people who currently or have in the past smoked, who were residents of Louisiana, who were smokers as of a date in, I believe, May of '96, provided that they had commenced smoking sometime in 1988.

Q. I believe there's an "or" in there, Doctor.

A. There are some other conditions.

Q. It's either you started smoking before or you make some allegations of fraud. Are you familiar with that?

A. I think there is a provision that there's an "or" with respect to behavior of the tobacco companies. And I can't quote to you what that language is. But there is an alternative prong, I believe, with respect to certain behavior of the companies, of the

defendants.

Q. All right. Now, you're not an expert in addiction; are you?

A. No, sir.

Q. And you're not an expert in cessation?

A. If by "cessation" we mean the medical processes of getting -- of helping people quit, that's correct.

Q. But you do have a general understanding of addiction and smoking; don't you? I mean, the same one that tobacco has indicated that everybody has?

A. Well, I don't know what tobacco has indicated.

Q. Okay.

A. But I know that there is one body of thought that involves a claim of addiction associated with nicotine; that the last time I read general literature on that, it was still being debated as to the extent to which that affected everybody or just some people or what the thresholds were.

Q. Well, do you know that tobacco contends in this case that everybody in the

State of Louisiana who is above the age of 18 knows that cigarettes cause addiction?

MR. STERN:

Objection to the form. No foundation.

EXAMINATION BY MR. BRUNO:

Q. Did you know that?

A. I do not know that from anything that I have reviewed in this case.

Q. Okay. Well, have they shared with you what exactly their position is on that point?

A. No, sir.

Q. All right. Do you know or at least do you have a general understanding that people who regularly smoke may be addicted?

A. I have a general understanding that some people who smoke regularly may have a dependency on the nicotine that occurs in that process.

Q. And do you know generally that people who smoke have some difficulty in stopping that behavior, that is, the smoking behavior?

A. I know that some people express

a desire to not smoke but say they have difficulty stopping.

Q. Right.

Do you also know people who have, in fact, stopped but express some urge, if you will, for lack of a better word, to pick up the cigarette again?

MR. STERN:

You mean does Dr. Long personally know such people?

MR. BRUNO:

Not personally, just in general.

A. Well, I guess both.

EXAMINATION BY MR. BRUNO:

Q. Sure.

A. I do know some people personally who have stopped smoking who have said that they get the urge every once in a while.

Q. Right.

A. I know some people who have stopped and restarted.

Q. Sure.

A. And stopped again and restarted again.

Q. And restarted again. Okay. All

right.

A. But, yes, I have firsthand knowledge of people like that. And in the general media coverage, I have read similar accounts of other people or populations.

Q. Right.

Okay. And as a general sense, do you know what the general medical recommendation is to those who have stopped smoking but who feel the urge to start again? Do you know that?

A. No, I don't.

Q. All right. At Tulane, do you know if physicians encourage individuals who have stopped smoking not to start again?

A. I don't know that of personal knowledge. I know physicians at Tulane, the ones that I know, uniformly urge people to stop smoking. I don't know and have never had occasion to ask or observe their telling someone who has already stopped not to resume. I just haven't.

Q. You've never heard of that?

A. I've just never observed that.

Q. That's fine. That's fine.

Do you think that's an unreasonable thing for a physician to do?

A. I don't think it's unreasonable. I guess it would involve some assessment or knowledge by the physician of the propensity of his or her patient to resume.

Q. Okay. Now, since you've had an opportunity to review Dr. Burns' depositions, have you been able to ascertain enough information to allow you to conclude how it is that he came to the numbers that he came to in the spreadsheets relative to the exemplar cessation program?

A. Tell me what you mean by "exemplar."

Q. The one that's attached to his report.

A. His cessation program?

Q. Right.

It's an example. Well, if you read the deposition, he said very clearly that it was an example of a cessation program. I mean, do you remember that, him saying that?

MR. STERN:

Well, objection to the form.

EXAMINATION BY MR. BRUNO:

Q. Okay. Do you remember him saying that or not?

A. I remember in his deposition his often characterizing things with respect to his spreadsheets as examples to the Court.

Q. Okay. All right. So we're on the same page is all I'm saying.

A. (Witness nods head affirmatively.)

Q. Now, so what have you learned about, if anything, about how he got those numbers that he put forth in the exemplar program?

A. My recollection is that I learned relatively little about the numbers. What I remember is his stating that his cost numbers were numbers that came from his personal experience with cessation programs, that is, the costs of each modality or method. That his differential -- I don't know whether it's propensity to quit or quit rates or proportion of long-term quits again were judgments which he had made based on his experience and not from any particular source.

Q. Okay.

A. And the other thing that I remember his saying is that he had, well, first of all, on its face, assumed that the current smoker number that he began with, which was six hundred and some thousand people was coterminous with the class.

And the one thing I guess which most surprised me was he actually put forth two notions that were possibly in the alternative, it wasn't clear to me, that when you -- that he believed that the costs of getting people to quit went up as you moved further into the defined group. That did not surprise me, per se.

Q. Right.

A. But that either that was such an important piece of his costing that it would have been simply trivial to have dealt with other adjustments which he left out, such as mortality in the class or differential quit rates given the program.

Or the alternative to that, as I appreciated it, was that because he didn't want to or couldn't estimate that additional cost, he would just leave the other things off or

leave the other things out kind of as an offset. And that he would assume that there, in some sense, were a wash.

Now, it was not clear to me which of those two alternatives was really -- He mentioned both of them and they were involved in questioning. But that the fact that he reduced his year-to-year class or what he was going to class the target population only by prevailing quit rates, not the quit rates that he envisioned in the program, and did not reduce the target population year to year by mortality was either because those things were trivial or because they were an offset to this increased cost as you move farther into the target population to get additional quits.

Q. All right. Well, let's start from the beginning. You said that it did not surprise you that the cost of cessation would increase over time in this population; right?

A. What I said was that the -- it did not surprise me that the costs per incremental quit would increase as you moved deeper into the population.

Q. All right.

A. Now, that's not --

Q. Why?

A. Okay. It seems to me to be consistent with ordinary knowledge that the people most motivated or most inclined to quit will be the people who quit first. That's early in the program. So you're not going to be spending multiple years' worth of money with respect to those people.

Q. All right. Let's talk about them, if you don't mind. Forgive me for interrupting but it's easier if we just kind of compartmentalize it. There is a group that you recognize, even though you're not an expert in this field, there are certain things that you know in general about the smoking population; right? That's what I'm hearing you say.

A. Right.

And, you know, I'm not sure which field we're saying I'm not an expert in. But there are certain economic characteristics of any population that would be --

Q. Well, we're not talking about the economic characteristics. We're talking about the fact that there is a, quote, most motivated

group. I mean, I could be missing something here, but that's not relating to their economic status or their -- anything like that.

It's a group of people who have a high degree of motivation with regard to desire to quit; right?

A. And I would say to you, Mr. Bruno, that that is part of their economic characteristics. We're not talking about how much money they make or that kind of economics. We're talking about their propensities to behave in a particular way. And economics is about behavior of individuals.

Q. Well, all right. But I guess -- I don't want to quibble with you, but it just seems to me that we're talking about the net economic impact that results from the fact that they are highly motivated, that is, it costs less to get those folks to cessate than it costs to get somebody who's not as highly motivated; would you agree?

A. I would agree with that.

Q. All right. All I'm saying is that this group of individuals is identifiable?

MR. STERN:

What do you mean by --

A. Well, --

MR. STERN:

Object to the form. I don't understand what you mean. You mean the individuals person by person?

MR. BRUNO:

"Yes" and "No."

EXAMINATION BY MR. BRUNO:

Q. I mean as a group of individuals, I mean, we're talking about them as a group, so that clearly means that they are identifiable, they can be separated from the other groups?

A. Well, there's -- they are clearly identifiable after the fact.

Q. Well, sure, yeah, because they quit.

A. Because they quit.

Statistically, certainly not individually, I can't point to Mr. A and Mrs. B.

Q. Right. We can't give you their names, yeah.

A. But statistically there is certainly the potential to identify some

proportion of this population which we would expect to quit in some fixed period of time, if only based on historical experience.

Q. Okay. Now, and what I'm driving at is with regard to this group, are you also able to identify the modalities that would be most appropriate with regard to assisting them with their desire to quit?

A. I think there's two pieces to that.

Q. Okay.

A. One is, again, based on historical experience. One can identify alternative modalities and their relative rates of success. I do not know, however, that, again, before the fact, one can match differing modalities to different subsets of that population and say, "This method is best for people exhibiting these kinds of characteristics and this method is best for people displaying some alternative set of characteristics."

Q. I don't mean what's best now. I said what would be appropriate. I didn't say the best, okay? Now, and I guess what I'm driving at --

MR. STERN:

Wait, wait.

A. Well, yeah. When I used the word "best," I was intending to mean efficacious, what would be most efficient.

EXAMINATION BY MR. BRUNO:

Q. Right.

Well, for example, with regard to the most motivated group, would you recognize that a message, a public service or a public -- Withdraw.

What I mean is that there is a message that is published through any number of sources, be it the television, be it advertising in magazines or the newspaper or the like which simply sends the message "Don't smoke." My first question is: Is that recognized as a cessation modality?

MR. STERN:

Objection to the form. I'm sorry, I don't understand the question.

MR. BRUNO:

Okay. I'm sorry you don't, either.

EXAMINATION BY MR. BRUNO:

Q. Doc?

A. When I think of cessation

modalities in the context of the medical care system, the healthcare system, I think in terms of specific interventions of the kinds that Dr. Burns identifies. You know, there's counseling, there's -- in person, by telephone, there's clinics, there's some drug interventions, et cetera.

Q. Right.

A. When I think about public health, you know, activities, you know, to me, it's one thing to attempt to change the behavior of a population or a subset of the population, that is, where you're dealing with a large number of persons having particular characteristics.

And, certainly, we see things like television advertising that tends to be directed toward, for example, teenagers or billboards or things like that that are trying to raise a level of awareness in a population that a particular behavior is dangerous or can harm you.

And I think of those kinds of programs differently than I think about the one-on-one kinds of things. How does the healthcare provision system interact with Mr.

Jones or Mrs. Smith to help them stop smoking, for example, when they say, "I'd really like to stop smoking. I've tried and I can't. Can you help me?"

Q. Well, I guess I'm confused because would you agree with me that the goal of the cessation program is to assist people who want to quit in quitting?

A. That would certainly be the commonsense goal of such a program.

Q. Sure. And what would be the difference then when you add the appellation "public health"? Isn't the goal the same, that you --

A. I'm sorry? When you add the --

Q. The appellation --

A. Oh.

Q. -- the title "public health," isn't your goal the same? You want that same population to assist them in cessating?

A. I think on the public health level, what you're attempting to do is motivate a segment of the population to seek assistance. When you start talking about cessation interventions at the level of the individual,

then you are responding to that desire, whether it was self-initiated or whether it was assisted by a public awareness, public health campaign.

Q. Well, I'm confused again because the kinds of programs that you just described are not programs that say, "Go get help." They simply say, "Stop smoking, smoking is bad for you." You know the drill here. They don't say, "Go to a doctor and go buy the patch."

A. Well, I don't know that they never say that.

MR. STERN:

Wait, wait, wait. Dr. Long, you have to wait until he asks a question.

THE WITNESS:

Oh.

EXAMINATION BY MR. BRUNO:

Q. But the point is, the message is that you have characterized is public health, in particular, the Heart Association message -- I'm sure you're familiar with those -- American Lung Association messages, they say, "Smoking is bad for you, stop smoking." Wouldn't you agree? I mean, that's the kind of message that

we've seen?

MR. STERN:

Object to the form. You've now asked this question three times. He's answered it.

MR. BRUNO:

Good. Good for you.

EXAMINATION BY MR. BRUNO:

Q. All right. Doc?

A. I have seen those kinds of messages, yes.

Q. All right. And my simple point is that those messages have as their goal to motivate people to stop smoking?

A. I think that is a fair characterization of that advertising.

Q. All right. And all I'm saying is that with regard to that highly motivated group, this is the group that might benefit from those kinds of messages; right?

A. Well, I would suspect that there are, in the so-called highly motivated group, people who are sufficiently motivated that they are attempting or have, in fact, stopped smoking, whether they had ever seen one of

those ads or not. There are others who may be more susceptible to those messages, that is, would change their threshold of motivation. And I suspect there are people who, you know, ignore it completely.

Q. Yeah.

Have you looked at the quit rates over time? Now, you can remember back in the sixties you didn't see very many messages out there saying, "Don't smoke." And then there was a period of time when they started appearing on television. I mean, don't you agree with me that as those messages started appearing, the quit rates went up?

A. Well, I have not looked at the data.

MR. STERN:

Object. Excuse me, Dr. Long. Let me object to the form because I think it -- I don't know if you mean to imply cause/effect or not, so I have to object.

MR. BRUNO:

Well, I don't know.

EXAMINATION BY MR. BRUNO:

Q. But, anyway, --

A. I have not studied a time series of quit rates.

Q. Okay.

A. I do know that there were lots of messages in the public arena before the kinds of advertising that we've seen most recently related to Surgeon General's warnings, to medical studies that get popularized in the daily press.

Q. Right.

A. There were lots of things which were not paid advertising that were conveying this message, you know, before, say, the last five years --

Q. Right.

A. -- when we've seen more of the media-type advertising.

Q. Did I hear you say that the best way to evaluate the effectiveness of a particular modality is to analyze it after the fact? Didn't you tell me that?

A. I said that we could look at a track record of different modalities --

Q. Right.

A. -- and see how effective they have

been, yes.
Q. Sure.
Okay. So I'm wondering have you -- what have you done to determine whether or not the publication of the message "You ought not smoke because it's bad for you" has been effective in assisting people in discontinuing their smoking behavior?
A. I have not done such a study.
Q. Okay. All right.
Okay. So you certainly, therefore, are not in a position to tell the jury or the judge whether or not the publication of the message would be an effective cessation method; right?
A. Well, again, when I think about cessation methods, I'm thinking about interventions with individuals. And the media notion is a population-level intervention.
Q. Well, but you just said you haven't looked at the numbers. Let me suggest to you that if you did look at those numbers and those numbers would, in fact, reveal that when the messages were published that the quit rates increased, if that were true -- I mean, take my

word for it for the purpose of this question -- if that were true, then one could logically conclude that publication of such a method would be an effective method of assisting people in quitting?

MR. STERN:

Object to the form. That's been asked and answered. And Dr. Long has told you, Joe -- and I think the Court has said the same thing -- that advertising is not a cessation.

MR. BRUNO:

No, that's not what the Court said. You weren't in court, so you don't know what he said.

MR. STERN:

I have read the Court's transcript.

MR. BRUNO:

Well, you misread them.

MR. STERN:

Well, I remember the Court saying there would be no recovery for advertising.

MR. BRUNO:

No. What the Court said was that

there would be no recovery for recruitment, which is what the Court said.

MR. STERN:

We just have to agree to disagree about that.

MR. BRUNO:

Well, that's what life is all about, I guess, is disagreement. But it has no place in this deposition.

THE WITNESS:

Could we have the question read back?

MR. BRUNO:

That's probably a grand idea.

THE WITNESS:

I think I may have lost it by now.

MR. BRUNO:

I'm sure you did.

(Whereupon the preceding question was read back by the court reporter.)

THE WITNESS:

Thank you.

THE COURT REPORTER:

You're welcome.

THE WITNESS:

A time coincidence, in the sense of simultaneous events or closely in time, does not guarantee that that is the reason.

EXAMINATION BY MR. BRUNO:

Q. I didn't say that.

A. It doesn't establish cause and effect, but --

Q. I didn't say that. I said assume that it's true. That's all I said.

MR. STERN:

No, no, no.

A. You said assume that these two things happened at the same time: The smoking rates increased as advertising occurred.

EXAMINATION BY MR. BRUNO:

Q. No, I said assume that I'm correct. I said because you haven't looked at the data, I'm not going to ask you to analyze the data. I'm going to ask you to assume for the sake of my question that, in fact, there is a connection between the publication of the notice and reduced quits, okay?

A. So it's not just a correlation?

Q. No, not a correlation.

A. It's a causation?
Q. And the reason I did that is purposeful. You didn't do the analysis and you haven't contacted or spoken to any experts who have done the analysis; correct?
MR. STERN:
Wait, wait, wait. What's the question? You made a statement and then you asked a different question.
MR. BRUNO:
No, I didn't ask a different question.
MR. STERN:
Are we back on your hypo or you're on to a new question?
MR. BRUNO:
No, we haven't left the hypo. Let me do it again.
A. So I'm assuming that there is --
EXAMINATION BY MR. BRUNO:
Q. Yes.
A. You're asking me to assume there is causation --
Q. Right.
A. -- between --

Q. The publication --

A. -- increasing of advertising and --

Q. Quit rates.

A. -- people actually successfully quitting?

Q. Exactly. Exactly.

And, again, I make the point -- And I don't want to belabor this, but I'm doing that to be fair to you because just to give you the -- you haven't done the analysis one way or another, so that's why I'm simply saying, okay, let's assume it, okay, to be true. This works. If it works, then would it not be an appropriate modality to be used in the context of this case?

MR. STERN:

Let me object to the extent that calls for a legal conclusion and to the extent the doctor has already said that he doesn't regard that as a smoking cessation intervention.

You can answer the question, Dr. Long.

MR. BRUNO:

That's noted.

A. If in your hypo that was the only thing which happened --

EXAMINATION BY MR. BRUNO:

Q. What do you mean by that? Now I'm confused. What do you mean the only thing that happened?

A. Okay. If we have this media campaign increase and that causes people to quit --

Q. Right. Not all, just --

A. An increase in the --

Q. An increase, yeah.

A. -- the number or proportion of --

Q. We've got our hardcore people that we haven't even talked about yet.

A. Right.

Q. We're talking about our highly, obviously, our highly motivated group.

A. If your hypo is that we can establish causation, and those people who do quit quit with no other intervention, they didn't chew the gum, they didn't have counseling, they didn't do any of the other things, if that were an absolute causative -- if we could establish that as a causative

thing, then that activity would clearly be something which would achieve or help us to achieve the desired end.

If it simply increased the proportion of people who then decided that they wanted to go use the gum or go see a doctor or go join a smoking-cessation program or any of the other specific modalities that we've talked about, then by itself I would not consider it a smoking cessation intervention.

Q. Exactly.

Indeed, and just so you and I can be clear and fair with each other, you just made the distinction between a recruitment effort, that is, "Y'all come on down and try our gum and our patch and our cessation program versus "You ought to quit." And those who are -- And then just hearing that message out there helps them or reinforces them or gives them that extra little push that they need to actually stop, that would be the cessation message; right?

A. Of exclusively their own volition.

Q. Right.

Okay. And, really, the analysis is

the same regardless of the modality, be it the patch, be it the behavioral modification? You look at the particular program and you look at the success rates?

MR. STERN:

Wait for a question.

EXAMINATION BY MR. BRUNO:

Q. Isn't that true?

MR. STERN:

That what would be the same?

A. If you --

MR. STERN:

I'm sorry. The modality would be the same?

MR. BRUNO:

No, I didn't say the modality was the same. Indeed, I said the modality was different.

MR. STERN:

I just --

MR. BRUNO:

I'm sorry you can't keep up with this. But, I mean, you know, don't misstate the question.

MR. STERN:

Well, I'm asking.

EXAMINATION BY MR. BRUNO:

Q. All I'm saying is this: That we agreed that the public information campaign might be, if I'm correct and there is some demonstrable causal link between the campaign and quit rates, that would make it an appropriate cessation modality?

And I'm simply pointing out the analysis is the same for all the modalities, be it the patch or be it the counseling and so forth? You measure the number of folks that come in, you measure the folks that come out, and then you figure out how many of those folks quit? It's the same kind of analysis is all I'm saying?

A. That would be, you know, a basic protocol for analyzing any intervention, yes.

Q. Right.

And for our purposes here, we don't want to pay for any modality that just flat out doesn't work? I mean, that would not be a good way to spend money; right?

A. That's correct.

Q. All right. But with regard to what

you bring to the table, it is the expertise that you bring, you're not -- you're not here to tell the jury which of these modalities is the appropriate one in a given group; right? In other words, you're not here to tout cessation by using the patch versus cessation by using the gum versus behavioral modification?

A. That's correct.

Q. All right. Now, so how do we then construct a program that includes appropriate modalities? How do we go about doing that?

A. Well, a program that for the purpose of increasing smoking cessation --

Q. That sounds like recruitment to me. That's why I -- Forgive me for interrupting you.

A. Okay.

Q. Before we get way down the line, let's just --

A. All right.

Q. -- we'll stop and make sure that you and I are not talking at cross-purposes.

What you said made me think increasing the number of people who would

participate. Is that what you meant?

A. What I had in mind was for whatever number of people are in the class --

Q. Okay.

A. -- to increase the rate of smoking cessation --

Q. Okay.

A. -- over what would occur, anyway, absent additional intervention.

Q. Okay. Now, we're on the same page then. All right. Now, so how would we do that?

A. The -- If the question is what are the components in the program --

Q. No, no.

A. -- what are the interventions -- You said how do we put together a program?

Q. Yeah.

I mean, you're an expert in this field. And I want to know how do I construct this program? What is the appropriate scientific methodology, if one exists, to build this program?

MR. STERN:

Objection to the form. I don't

understand "build the program," what you're looking for.

EXAMINATION BY MR. BRUNO:

Q. Okay. Do you understand my question?

A. Well, I may or may not. I can --

Q. Okay.

A. We will find out as I suggest the piece of an answer.

Q. We've successfully done that all 20 minutes long, so I'm happy to continue on this course.

A. I mean, as you mentioned earlier, we do not wish to include things which are not efficacious.

Q. Precisely.

A. We do wish to include things which are efficacious.

Q. Right.

A. Knowledge of what is efficacious has to do, in part, with existing modalities which one can observe have, in fact, been associated with successful quits.

Q. Okay. And where -- This is not within your area of expertise? We've got to

consult some other experts, right, as to --

A. We would need to look at people who have expertise in smoking cessation, delivery of these programs, who would have data that would say, you know, people came and used the patch and this many of them actually stopped smoking a year -- by a year later were still off cigarettes.

Q. Okay. Now, do you offer in this case an expert opinion as to whether or not the particular programs identified in the exemplar program are good or bad or inappropriate or the like?

A. I do not.

Q. Okay. All right. So let's assume then for the sake of our discussion that these are appropriate modalities, the ones, that is, the ones which are identified in the exemplar program. What is the next step that we should go through to determine what money would be necessary to fund such a program over the course of one year?

A. Well, the next step is to identify what would need to occur that would increase the effectiveness of these interventions and/or

to find new interventions perhaps not currently being used.

Q. Okay.

A. That is, what is it -- If we were talking about the patch, for example, and, you know, ten people out of a hundred who used the patch really do quit, what is it that you could do so that fifteen out of a hundred people who used the patch would quit? In other words, what intervention, further intervention beyond the existence of the modality would get you better results than you're already getting?

Q. Got you.

Would that relate in any way to what Dr. Sarah Moody-Thomas refers to as adherence or retention?

A. I think it would relate to both of those things.

Q. Okay.

A. You know, it is, you know, who shows up.

Q. Right.

A. You know, "A" wants to quit --

Q. Right.

A. -- "B" wants to try this modality,

"C" continues to use this modality, "D" is successful --

Q. Got you.

A. -- in using this modality.

Q. All right. So, all right, how do we go about doing that? How do we determine -- Do we go to the patch makers or the scientists who know about the patch?

MR. STERN:

To do what?

MR. BRUNO:

To do what the doctor just suggested we needed to do in the first place, which was to assess the effectiveness of that modality.

A. Well, I'm assuming that each of the modalities is effective in the way that we've already described.

EXAMINATION BY MR. BRUNO:

Q. Right.

You said to improve the effectiveness.

A. To improve the effectiveness --

Q. Right.

A. -- I'm sure it will be some

different set of steps for each modality.

In the case where we're using some sort of a product, it may, in fact, involve product design or modification to make it more user friendly or attractive or whatever. In the case of services that don't involve a product, such as counseling, it may be a question of accessibility, training of personnel.

I mean, it's going to clearly be different kinds of things with respect to different modalities.

Q. Okay. All right. Well, how do we determine the cost? How do we figure that out?

MR. STERN:

You mean for the -- what you're calling the exemplar cessation program?

MR. BRUNO:

No. The cost of what the doc and I are building, which is our own program.

MR. STERN:

Well, Joe, you're building it. The doctor is talking about costs. But I don't --

MR. BRUNO:

Yes.

MR. STERN:

I mean, you're improperly characterizing his testimony when you say he's building a program.

MR. BRUNO:

No, I'm not incorrectly characterizing his testimony. Not in the least.

EXAMINATION BY MR. BRUNO:

Q. We've just described the fact that if we were going to do this, we would identify the modalities. You've agreed with me that that's outside of your field of expertise. So I've asked you to assume -- understand that it's an assumption -- that the modalities identified in the Burns exemplar program are the right ones.

So the next step is, all right, what do we do next? And you said that what we want to do is try to figure out, one, what can we do to improve their effectiveness; and, two, we need to explore whether there might be some new interventions out there; right?

A. I would presume that there is somewhere in the medical and public health

community research going on that would be looking for additional ways of helping people stop smoking.

Q. Okay.

A. And if there has been such research, then, you know, it would -- If a new modality has been proven empirically, then it certainly would be eligible for inclusion in such a program.

Q. Yes.

Now, this is your area. This is your field of expertise; is it not? I mean, that is the business of the economic considerations of -- that would drive things like this research that you just talked about, that's a subject about which you have expertise?

MR. STERN:

Objection to the form.

EXAMINATION BY MR. BRUNO:

Q. Right?

A. I'm not sure what you mean by driving the research.

Q. Well, you just made an interesting point to me. And you said if the research

exists or if anybody is doing it; right?

A. Yes.

Q. All right. The fact of life in this country is that somebody is only going to do it if somebody else is paying for it; right?

A. Or if somebody believes that they will get a payoff in the future, they may be paying for it themselves.

Q. Right.

Well, the point is it's economically driven?

A. In --

MR. STERN:

Wait for a question. Wait for a question.

EXAMINATION BY MR. BRUNO:

Q. Isn't that true? Please.

A. There are two basic scenarios in which this could occur. One might be the thirst for new knowledge, in which case there could be public sector funding, such as National Institutes of Health or National Science Foundation or whatever. It could be a profit motivation. A pharmaceutical company engages in activity because it thinks there's a

reasonable prospect of a profit somewhere down the line in the future.

Q. Right.

And my only point is it's more basic than dividing the source of the money? If there's no income source -- I shouldn't say income source. If there's no source of money, the research is not going to happen using both scenarios? If there's no public sector financing and if there is no perceived profit motive, the research just doesn't happen; isn't that true?

A. As a general proposition, I think that would be correct.

Q. All right. So that in the case of modalities with regard to cessation, I mean, to bring it home, either, A., there has to be a public funding source for research as to improved or more effective cessation methods; correct? Or there has to be a company out there who believes that if they develop this method, they might be able to sell it to the public and derive a profit therefrom; right?

A. I think those would be the two most likely scenarios.

Q. Okay. All right.

MR. STERN:

Can we take a bathroom break, Joe?

MR. BRUNO:

Of course. Any time.

THE VIDEOGRAPHER:

We're going off the record at 2:30.

(Whereupon a brief recess was taken at this time from 2:30 o'clock p.m. to 2:37 o'clock p.m.)

THE VIDEOGRAPHER:

We're going back on the record at 2:37.

MR. BRUNO:

Okay. What was the last question?

(Whereupon the testimony on Page 341, Line 15 through Page 341, Line 25 was read back by the court reporter.)

EXAMINATION BY MR. BRUNO:

Q. All right. And the final question in that line is just because there's no funding doesn't mean that the research is not important and necessary? I'm sorry. Just because there's no funding, it doesn't mean that the research may not be important and necessary?

A. The judgment about important or necessary is made by funding sources. And they will fund that research they believe to be important and necessary.

Q. Well, what public funding is there for new cessation modalities?

A. I have no idea.

Q. Okay. And what research do you know of that private industry is undertaking for the determination of new cessation modalities?

A. I'm sure that's proprietary. And I don't know what's currently underway.

Q. But you would agree that it is important and necessary to have research to find new cessation modalities; correct?

A. I think what I've said is that research deemed to be important and necessary will be funded.

Q. All right. So that doesn't answer the question.

Do you agree or disagree that there should be research to identify new cessation modalities, regardless of whether it's being funded or not?

A. I have no opinion about that.

Q. Why not? You just told me a few moments ago that the two things that we want to look at were to -- whether to seek methods of increasing the effectiveness of the modality, and the second thing you said was to look for new interventions. Those are your testimony.

A. No, my --

MR. STERN:

Objection to the form.

THE WITNESS:

My testimony was that if Dr. Burns were putting together a program, he should certainly consider new modalities, if there are any. I don't happen to know if there are any.

EXAMINATION BY MR. BRUNO:

Q. All right. So you weren't saying that there should be research to identify these modalities? You didn't say that?

A. No.

What I intended to say is that if someone perceives a need for new modalities or the prospect of improved modalities, they should be willing, either publicly or

privately, to fund research which would demonstrate that to be the case.

Q. Okay. All right. Now, so we've identified our modalities and we've identified the fact that we should be looking for ways to improve effectiveness. How do we determine the costs of those items?

A. The costs of particular interventions can be estimated in the same way that one estimates the costs of other medical interventions or procedures.

Q. Okay.

A. By looking at the resources that are required to deliver the service and finding out what they cost.

Q. All right. Did you do that for the cessation program?

A. No, I have not done that for the cessation program.

Q. Okay. Can you do that? Do you have the ability?

A. If I have a clear statement of each of the interventions --

Q. Okay.

A. -- and exactly what they involve,

that is something I can do.

Q. All right. And are you telling me that you didn't have that in this case, you did not have a clear statement of the interventions?

MR. STERN:

Objection to form. He didn't say that.

EXAMINATION BY MR. BRUNO:

Q. Well, I'm asking what did you say?

A. The modalities which were listed by Dr. Burns were very generic in their nature and not -- did not have sufficient detail that I would know how to go about costing them.

Q. He says, "Pharmacologic assistance." You did not have enough information to detail the cost of pharmacologic assistance?

A. He lists two or three example chemical compounds, I gather.

Q. Right.

A. Doesn't say anything about frequency, administration, do they require physicians, do they require other professionals. There just wasn't enough detail

52434 7928

there for me to know what that intervention was.

Q. Did you find anywhere in Dr. Burns' deposition where the tobacco lawyers asked that question?

A. The question I recall being asked was: "Where did you get the costs for each intervention?" And I understand his response to have been: "They were personal judgments based on my experience."

Q. That wasn't my question.

You, presumably, have talked to the lawyers that hired you and you've told them what you need in order to evaluate Dr. Burns' exemplar plan; right?

MR. STERN:

Objection to the form.

A. I have --

EXAMINATION BY MR. BRUNO:

Q. Have you done that? "Yes" or "No"?

A. I have indicated in my report and, also, in conversations with the attorneys who hired me the kinds of information that I would need to do that exercise.

Q. Okay. Well, did you tell them what

you just said on the record, that you needed to know more about the pharmacologic assistance, you needed to know whether or not it was doctor prescribed and the like? Did you tell them that?

MR. STERN:

Objection to the form. Joe, you're implying improperly that he should have. It's not the defendants' burden to cost out Dr. Burns' program. That's Dr. Burns' or the plaintiffs' burden. He's already said he didn't do that.

MR. BRUNO:

I'm not implying that at all. You told the judge that he couldn't give an opinion. And you told the judge that you needed to depose Dr. Burns to get information in order to get him an opinion. And you took three days and you never asked that question. That's my only point. And I want to make it crystal clear that that's what happened.

EXAMINATION BY MR. BRUNO:

Q. You, when I deposed you in November, you said you didn't have sufficient

information in order to properly critique the program; right? You told me that?

A. I did.

Q. And you told these lawyers that they needed to go depose the guy to get the information that you would need in order to do a proper critique; right?

A. That -- Not in those words, but --

Q. Close enough; right?

A. I did say that --

Q. All right.

A. -- since it was not contained in his report or his spreadsheets, that it would be nice if we asked the questions in the deposition.

Q. Go ask the questions.

All right. You told them what questions they ought to ask, too; didn't you?

A. I did not specify -- No, I did not write out individual questions for them.

Q. You didn't write out the questions but you told them what information you needed?

A. That I needed enough information to do this. And they, in fact, asked Dr. Burns: "Where did you get your cost figures?"

Q. And I ask you, once again, did you see in those depositions, all three days, all those pages, did you see the question: "Dr. Burns, with regard to the pharmacologic assistance that you have indicated on Page 1 under Subparagraph A, did you, Dr. Burns, include in that the cost of a physician dispensing the medication?" Or a question even remotely like that? Was that in there?

A. I did not see that question.

Q. All right. Did you see any questions that asked Dr. Burns to detail the pharmacologic assistance to which he makes reference in his cessation benefit program on Page 1?

MR. STERN:

Joe, if you want to ask him about the deposition, unless you just want it to be a memory test, I would ask that you show him the deposition. There were lots of questions about the pharmacological interventions. If you want it to be a memory test, go ahead.

MR. BRUNO:

Counsel, I don't want to play games

with you. It's not a memory test. You said, you told the judge that he needed to have the deposition. He's now got the deposition. And you still don't have enough information to critique his cessation program; isn't that true?

MR. STERN:

There is no burden on defendants to critique his program. There is no burden --

MR. BRUNO:

You're forgetting, Counsel, no one is suggesting that you have the burden. I'm suggesting that you told the judge some things that are not true.

MR. STERN:

That is absolutely false.

MR. BRUNO:

Then let me ask my questions and we'll have the judge resolve it, okay?

MR. STERN:

Fine.

But this deposition is not the place for you and us to have this argument.

MR. BRUNO:

On the contrary, it is.

EXAMINATION BY MR. BRUNO:

Q. The doctor made representations in his depositions. He said, "I'm not going to be prepared to finish this deposition until such time as we completed Dr. Burns."

Do you remember that? And that's why we waited till now to do this deposition. Do you understand, Doctor, that that's why we're taking your deposition now?

MR. STERN:

Dr. Long, just a minute. Objection to the form. Joe, this is becoming argumentative. You're not asking questions; you're arguing with the witness.

MR. BRUNO:

Good. It's all noted.

EXAMINATION BY MR. BRUNO:

Q. Do you understand, Doctor, that the reason why your deposition is taking place now is because I had to allow the defendants an opportunity to complete their deposition of Dr. Burns? Did you understand that?

A. I understand that the defendants

from the beginning have suggested that my deposition would best be taken after the plaintiffs' expert had disclosed all of his information.

Q. Okay. All right. And, in fact, now the deposition of Dr. Burns has been finished, right?

A. I will accept that as a representation.

Q. Yeah. And what I'm trying to --

A. I have a volume that doesn't say it's the last word but it does say --

Q. You're right. You've got a good point there. It doesn't say it's the last word.

What I want to know is what do you know now, from having reviewed Dr. Burns' deposition, that you didn't know when I took your deposition in November that will help me find out what your opinion is about the schedules that relate to the cessation program? And I can move on to the next subject.

A. What I know is that he stated in his deposition that the cost per service for each of the intervention modalities were

personal judgments based on his experience.

Q. All right. Are you in a position to tell the judge or the jury whether or not his cost estimates, based upon his own personal experience, are appropriate or inappropriate?

A. I cannot find a -- I mean, this is not the approach that would come from an economist which would tell me: "Here are the component parts of this intervention and here's where I got the costs." I don't have that information.

Q. All right. But that's not my question.

The question is whether or not you are in a position today to say whether or not his cost estimates are appropriate or inappropriate?

MR. STERN:

Objection. He just answered that question.

MR. BRUNO:

No, he didn't.

A. They are inappropriate as to methodology.

EXAMINATION BY MR. BRUNO:

Q. Okay. Well, do you have any experience with cessation programs?

A. I do not.

Q. All right. Do you know what experience Dr. Burns has with cessation programs?

A. That was covered in his deposition. And my recollection is that he had some experience with a California program and some broad acquaintance with cessation programs in conjunction with things he had done in Washington. But that there were no particular cessation programs, for example, at San Diego that he had been involved in.

Q. You say some. He testified that he helped write the California Tobacco Control Program. Did you miss that in his deposition?

A. I think I mentioned that he had, the experience he had was with --

Q. No, not some.

A. -- a California program.

Q. Right.

But let's talk about what that is. The California program contains a cessation program which is funded by the tobacco tax

there which has specific modalities that are offered to the public at large; isn't that true?

A. I haven't --

MR. STERN:

Objection. There's no foundation.

THE WITNESS:

I do not know that that is true.

EXAMINATION BY MR. BRUNO:

Q. Well, what did you do to find out?

A. Why would I need to find out?

Q. Because you just testified that you now know what experience he's got with regard to the assessment of the costs. And if you know what that experience is, it seems to me that you want to make inquiry about what it is that he did in the California Tobacco Control Program.

And if you didn't do that, then fine, then I'll have my answer.

MR. STERN:

Objection.

A. I haven't had any --

MR. STERN:

Wait, wait. Objection to the form.

There's no question on the floor.

MR. BRUNO:

That's fine.

EXAMINATION BY MR. BRUNO:

Q. Doctor, would you please answer?

A. I have not had the opportunity to communicate with Dr. Burns about what he did in California.

Q. All right. Well, then you don't know whether or not he has personal knowledge of the cost of each of these modalities; right? You don't know one way or the other?

A. He testified that he put those numbers down based on his personal experience.

Q. I understand.

So that you have no way then to test whether or not he's right or wrong because you don't know what his experience is with regard to the cost of these services; isn't that true?

A. That is what I said. I've not had the opportunity to ask him or talk to him about what it was he did.

Q. Okay. So you can't say whether or not his numbers are too high or too low?

A. Not on the basis of his testimony, that's correct.

Q. All right. I mean, somebody could have asked those questions when they were taking his deposition; right? I mean, they could have asked him specifically: "What is your experience with regard to pharmacologic assistance as it relates to nicotine replacement therapy?" Somebody could have asked that question?

A. I have no reason to think they could not have asked that question.

Q. All right. What about telephone cessation counseling? Do you have an opinion as to whether or not the numbers that Dr. Burns used are appropriate or inappropriate for the cost of that modality?

A. I do not.

Q. How about with regard to physician, dentist and other clinical advice to quit smoking and counseling to quit smoking? Do you have any opinion as to whether Dr. Burns' numbers on that are high or low or otherwise?

A. It is quite unclear to me what is meant by this item, in both his deposition and

the report, as to whether this constitutes a separate service or an add-on to some ongoing encounter. And why it would be an incremental cost.

Q. Well, was the question asked in the deposition as you just --

A. I do not recall seeing the question in the deposition.

Q. And I'm sure you told the lawyers what you needed in order to assess the cost of that particular component of the plan; didn't you?

A. I for not only this but for a number of other things indicated that we didn't have any sources or authorities in Dr. Burns' report or spreadsheet.

Q. Okay. And you still don't even today as you sit here; right?

A. For a number of items, I still do not have authorities or sources.

Q. All right. Well, I don't want to hear a number of. I want to be specific to the cessation program. Do you have numbers or authorities for, on Page 1, Number 1., Letters a., b., c. or d.?

A. I need to see the page to be able to --

Q. And I will be more than pleased to show it to you.

A. (Witness reviews document.)

MR. STERN:

Okay. Can you show it to me, too, please?

MR. BRUNO:

As soon as the doctor finishes looking at it.

MR. STERN:

You just have this one copy?

MR. BRUNO:

You must have eight billion copies of the cessation program circulating.

MR. STERN:

I'm sure you're right, but I don't have one with me.

MR. BRUNO:

Well, I don't know what -- Do you need to have another copy of it in order for me to complete my --

MR. STERN:

I'd like to be able to follow along.

But if this is -- if you're just going to ask this question and move off, I'm fine. This is out of Dr. Burns' report, I take it?

MR. BRUNO:

Correct.

THE WITNESS:

Could we read back the question that ends with a., b., c. or d.?

(Whereupon the preceding question was read back by the court reporter.)

THE WITNESS:

With respect to the cost of providing each of a., b., c. or d., I do not.

EXAMINATION BY MR. BRUNO:

Q. You do not.

All right. Even after the completion of the deposition of Dr. Burns; isn't that correct?

A. If it has been completed.

Q. Well, I think we can assume for the sake of this discussion that it has been completed. At least the lawyer said, "I'm finished." And we all got up and we left.

52434 7943

Do you have any criticisms of the cessation program that resulted from anything that you learned from the completion of Dr. Burns' deposition?

MR. STERN:

Do you mean the modalities or Dr. Burns' assessment of costs?

MR. BRUNO:

I mean anything, anything at all. I'm not going to limit it to anything. I mean, y'all said you had to complete the deposition and now it's finished.

EXAMINATION BY MR. BRUNO:

Q. So what, if anything, did you learn in that deposition that allows you to offer some new opinions that you couldn't give me when we were here last November?

MR. STERN:

Well, let me object. That question is so incredibly broad it's impossible to answer. Why don't you take him through the deposition and ask him for his opinion on Dr. Burns' testimony?

MR. BRUNO:

Why should I do that? You're the

ones who said you had to finish the deposition. I'm entitled now to know what you've learned as a result of having finished Dr. Burns' deposition.

MR. STERN:

Joe, I would just suggest that if you really want to know his reaction to Dr. Burns' testimony that you show it to him.

MR. BRUNO:

No, I would suggest that you read Case Management Order Number 2, Paragraph 11, which requires you to give to me a complete expert report, which you didn't do because you said that you didn't have Dr. Burns' completed deposition.

So I'm the one that's being put out, not you, because you have never given me a complete expert report from Dr. Long. That's why I'm in the position -- And forgive me because I wouldn't ordinarily have to ask the question that way. Ordinarily, I'd have a report. And it would say I think this, this, this, this and this.

EXAMINATION BY MR. BRUNO:

Q. But we've already covered this ground, Doc. You said, "I didn't have enough information. And I met with the lawyers and I told them what I wanted." And they did their thing and now their thing is finished and now you've got the report.

So I have to ask you, because I have no other way to do it, what have you learned, if anything, as a result of that deposition with regard to a critique, if you have any more -- I mean, I know you said some things last November -- but do you have anything to add to your critique of the cessation program, the spreadsheets that relate to it and the like, okay? That's my question.

MR. STERN:

And I would just continue the objection. It's overbroad.

MR. BRUNO:

It's noted. It's your fault it's overbroad.

MR. STERN:

Now, if you're going to say that, then I have to respond.

MR. BRUNO:

Well, it is your fault. I don't -- Do you want to show me your supplemental report? Do I have one? Do you have one to show me?

MR. STERN:

Joe, if you want to try and take up time to make this deposition go longer, that's your right.

MR. BRUNO:

That's a simple question. Do you have a supplemental report? "Yes" or "No"?

MR. STERN:

If you want to take up time, rather than asking Dr. Long questions --

MR. BRUNO:

That's funny. I don't have an answer to that question.

MR. STERN:

-- with colloquy between us, that's your choice.

MR. BRUNO:

Because you don't want to answer.

MR. STERN:

But Dr. Long gave a report, that report is complete, it does have opinions on cessation. If you want to ask him whether he has new opinions in view of Dr. Burns' testimony, that's your prerogative.

MR. BRUNO:

That's what I just asked.

MR. STERN:

All I would suggest is that you show him Dr. Burns' testimony and let him respond point by point.

MR. BRUNO:

I'm not going to, look, I'm not going to --

MR. STERN:

Otherwise, it's overbroad.

MR. BRUNO:

My point is if you didn't want to give me his report like you were supposed to do, then it's your problem, okay? I mean, the deposition says what it says. There are pleadings that you filed in court saying that you couldn't even address this issue because you wanted to finish Dr. Burns. This is something

you've told the Court, so you've got to live with it.

EXAMINATION BY MR. BRUNO:

Q. I'm just trying to find out what, if anything, that you want to add. So do you have anything on the cessation side of it? And then we can move on.

A. Yes.

Q. Okay. And that would be?

A. First, that Dr. Burns did not have any specific citations or authorities for his cost estimates of each intervention modality per person served.

Q. Wait. That's what you said in November. That's exactly what you said.

A. Now I know from his deposition -- You asked me what I learned from his deposition. He said I -- these are personal estimates, they're not from some authority or citations from a particular program.

Q. Now, wait a minute. He's the authority. You don't regard him as an authority?

MR. STERN:

Objection. Argumentative.

MR. BRUNO:

No, that's not argumentative.

EXAMINATION BY MR. BRUNO:

Q. Do you -- If you don't, it's okay, it's no big deal. If you're telling me "I do not regard Dr. Burns as an authority," then that's fine. But he has quite a reputation in this field; doesn't he?

A. I have no idea what his reputation in this field is.

Q. Did you check it out?

A. I have a copy of his C.V.

Q. That's it?

A. That's it.

Q. All right. So you don't have any idea about whether or not Dr. Burns is recognized in this country as one of the leading experts with regard to tobacco control? You don't know that one way or the other?

MR. STERN:

Objection to the form.

A. That's correct.

EXAMINATION BY MR. BRUNO:

Q. All right. And I merely asked the question if, in fact, he is a well-recognized

expert in the field -- and that's an if -- then he might be able to be his own authority on these things; isn't that true?

MR. STERN:

His own authority for what drugs cost?

MR. BRUNO:

Yes. Yes. Obviously, yes.

Doctor?

MR. STERN:

In lieu of sources? Okay.

MR. BRUNO:

Yes.

EXAMINATION BY MR. BRUNO:

Q. He could be a source; could he not?

A. I think he could be a source on matters medical.

Q. Okay.

A. I have not seen anything in his C.V. or, for that matter, in any of the other materials that have been presented to me or in his depositions that would suggest to me that he has any expertise in health care, economics or costs.

Q. Do you have to be an expert in

health care, economics or costs to know how much it costs to buy a patch?

A. You do not.

Q. Okay. Do you have to be an expert in economics to know how much a dose of bupropion -- and forgive my inability to say it -- costs?

A. No, but it would be useful if you had some understanding of costs and payment.

Q. Okay. Well, you can call the local drugstore here and you can find out, if you wanted to, the cost of bupropion; could you not?

A. You could get that piece of information from a drugstore and it would be a completely inappropriate piece of information if you were trying to determine the costs of this program.

Q. All right. Well, how would you do it? Then if that would be inappropriate to call the drugstore, how would you do it?

A. The way that any program would be costed would be to look at the quantities of any particular product that would be used, the way in which it would be administered. And

then with that information, find out what kinds of costs are consistent with that level of volume and that kind of distribution.

Q. All right. So what did Dr. Burns do to assess the quantities used?

A. Apparently nothing.

Q. Okay. Well, what can you do?

A. What can who do?

Q. What can a person do to assess the quantities that would be used?

A. One would need to specify what is required for each participating individual, over what period of time, with which intensity, and determine necessary quantities from that kind of information.

Q. Okay. And who might you talk to to learn that?

A. You would start with talking to the person who is designing the substantive medical content of the program.

Q. Which would be Dr. Burns?

A. Dr. Burns.

Q. Well, okay. So we're kind of back to square one then; aren't we? Since he's the guy that made the estimates?

A. And Dr. Burns hasn't specified that.

Q. Well, he wasn't asked the question, either; was he? Nobody asked him the question: What was the quantities that would be used on a per person basis? I was in the deposition. That question was not asked.

MR. STERN:

Dr. Long has already testified that Dr. Burns did answer that question.

MR. BRUNO:

No, he didn't.

MR. STERN:

He said he gave his personal judgments.

MR. BRUNO:

No, that's not what he said.

MR. STERN:

Well, you can ask Dr. Long.

MR. BRUNO:

You can re-read the deposition.

EXAMINATION BY MR. BRUNO:

Q. Dr. Burns was not asked the amount of ibu -- sorry, of bupropion or clonidine or nicotine replacement therapy that would be used

on a person-by-person basis unless your memory is different; isn't that true? That question was not asked by the lawyers?

A. My recollection would be that that question, as you have stated it, was not asked by the lawyers.

Q. All right. But going back to what you just said, though, the person to ask is the guy that's going to be the one who's assessing how much of these drugs or nicotine replacement should be administered, which in this case might be Burns. But are there some other people out there that we could talk to?

A. Well, it's my appreciation that Dr. Burns is the author of this program.

Q. Right.

A. And from my perspective, that makes it his responsibility to define the program in sufficient specificity that one can analyze its costs. That has not been done. It wasn't done in his report, it wasn't done in his spreadsheet. And all he said in his deposition was that he had used his personal estimates.

Q. That's correct.

And there's nothing that prevented

the lawyer from delving into how he came to those personal estimates; was there?

A. There was possibly a time constraint, but I don't have personal knowledge of that.

Q. All right. Nobody asked him what he thought would be an appropriate dose of bupropion or appropriate dose of clonidine or appropriate course of nicotine replacement therapy, nobody asked him that question; right?

MR. STERN:

Objection. It assumes that somebody should have. But go ahead.

A. I did not see that question in the transcript.

EXAMINATION BY MR. BRUNO:

Q. All right. And somebody should have asked him that question if somebody wanted to know with specificity how Dr. Burns calculated his numbers; isn't that true?

MR. STERN:

Objection. Dr. Long has just testified that he feels that it was Dr. Burns' responsibility to affirmatively offer that. You're asking the same

questions over and over and over again.

MR. BRUNO:

Then why do you keep coming up with different objections then? You're getting more creative as time goes by?

MR. STERN:

I think they all fit.

MR. BRUNO:

I don't think any of them fit, but -- So answer my question.

THE WITNESS:

Which was?

MR. BRUNO:

Which was -- Well, let's read it back. And we will need another day.

MR. STERN:

Let me state for the record, Cheryl, that we do not agree to another day.

MR. BRUNO:

Look, you started this deposition at 1:30. It wasn't by my choice.

MR. STERN:

We have already agreed for this deposition to go forward after the deadline. There is no reason that this

deposition can't be completed today. We do not --

MR. BRUNO:

There is every reason, particularly since counsel keeps interjecting with inappropriate and unnecessary objections, there's no way we're going to finish. And I'm telling you now you chose to start at 1:30. I was available to start at 9:00 o'clock. But you wanted to do this and you did it on purpose.

MR. STERN:

Joe, as you --

MR. BRUNO:

Now you have to suffer the consequences.

MR. STERN:

Joe, as you say that, you're talking over me. Dr. Long teaches. He has a schedule of classes he has to teach.

MR. BRUNO:

Okay. So that means we can reschedule. Doctor, --

MR. STERN:

For the record, we're not agreeing

to reschedule.

MR. BRUNO:

Well, that's fine.

MR. STERN:

But we'll argue that later.

MR. BRUNO:

Take it up with the judge.

MR. STERN:

Okay.

MR. BRUNO:

Now, we need to get the question since the doctor forgot the question.

(Whereupon the preceding question was read back by the court reporter.)

EXAMINATION BY MR. BRUNO:

Q. Isn't that true? That was something that was deemed to be necessary.

A. There are two ways to get the information: For Dr. Burns to set it forth in his role as an economist in his report or spreadsheets, or for defendants to attempt to get it through some other discovery means.

Q. Okay. All right. Now, what other critiques do you have of the cessation program that you didn't have before November?

A. The -- That he did not have a specific basis for the positive incremental changes in participation or quit rates against the background rate which he reported, the way things are happening currently.

He did not have a basis, again, other than personal judgment, for the increments in number of people utilizing a particular modality or the proportion of those people who would, in fact, successfully quit in the presence of his program compared to in the absence of his program.

Q. I'm sorry. I did not follow any of that. Start with the positive incremental stuff.

A. Okay.

Q. Let's start at the top.

A. Let's start it again.

He reports in his spreadsheet for the existing state of the world the number of people who attempt to quit, who attempt to quit using each of the modalities, and the proportion of them who are successful.

Q. Why don't you show me what you're referring to. I have here the budget.

A. It would be on the second of the three sheets.

Q. Okay. Here's the second of the three sheets.

A. (Witness reviews document.)

Q. Let's mark that as "Long Number 4."

(Whereupon the document as described above was marked as "Long Exhibit Number 4.")

EXAMINATION BY MR. BRUNO:

Q. All right. And why don't you circle what it is that you're complaining about.

MR. STERN:

Joe, just for the record, which exhibit is this out of? Out of Dr. Burns' deposition? I mean, he had many spread-sheets. Is this the one that Dr. Burns said was the final?

MR. BRUNO:

No, this is the one that you were given as a part of his report.

THE WITNESS:

This is -- I recognize this as one of the three, excuse me, the three pages

of spreadsheets that were part of the original report.

MR. STERN:

Okay.

THE WITNESS:

Okay. There is -- There are two columns here which I will note, label "Current," which are "Percentage of quit attempts" using each modality and the current real-world effectiveness of those modalities.

Then there are two more columns which he calls "Potential fraction of quit attempts" using that modality and "Potential effectiveness" in which in all of the instances on proportionate people who go for that particular modality.

And in most of the instances of, other than "Self," where the potential effectiveness is greater than the current real-world effectiveness, the potential -- the percentage of persons opting for a particular method is greater than in the current world.

EXAMINATION BY MR. BRUNO:

Q. Bottom line, the people who are using the program are more than the people who are currently using this particular --

A. More use each particular method.

Q. Okay.

A. And a larger proportion of those who use the method, not just a larger number, but a larger proportion of those who use the method are successful.

Q. Okay.

A. Okay?

And what I learned from the deposition is that just as is the case for the cost of service, that these higher numbers in proportion using the program and higher numbers in terms of proportion of successes were, again, personal judgments on his part without citation to specific experience or authority.

Q. Okay. And so what is your suggestion about how to do that?

A. Well, what I need is a basis upon which to know that these numbers weren't simply picked out of the sky someplace.

Q. Well, let's see if we can understand how this is going to work. If we

win this case, you understand there's going to be a separate phase for determining how much money should be put in a fund to pay for this; right?

A. That's --

MR. STERN:

Objection to the form. Go ahead.

EXAMINATION BY MR. BRUNO:

Q. Is that true?

A. It's my understanding that the judge has indicated that, the Court has indicated that there would be, assuming liability was determined --

Q. Right.

A. -- a separate process for proceeding to look at damages.

Q. Okay. So what I'm hearing you say is that you, on behalf of tobacco, are not going to tell the Court what you think the number should be; right? You're just going to attack Dr. Burns' methodology for his number?

A. I am, A., not designing a program.

Q. All right. I understand that. That's not my question.

A. Okay.

MR. STERN:

No, no, he wasn't finished.

MR. BRUNO:

All right.

THE WITNESS:

B., am -- have been asked to make an assessment or a critique of a program being designed by Dr. Burns.

EXAMINATION BY MR. BRUNO:

Q. Right.

Well, we've pretty much already established that. And that's what I just said.

A. And to assess the costs, whether the costs which he is setting forth for his proposed program appear to be reasonable.

Q. All right. Well, that doesn't answer my question because here's the question.

A. Okay.

Q. We win the case, there's another phase at which the Court is going to figure out how much money tobacco should pay for cessation; right? We've won now. Now it's how much?

A. (Witness nods head affirmatively.)

Q. So do I understand that you --

Well, do I understand that tobacco is not going to tell the judge how much they think should be put into a program to fund cessation?

MR. STERN:

Objection. Dr. Long can only answer for Dr. Long. And I think he's already answered that question for Dr. Long.

EXAMINATION BY MR. BRUNO:

Q. Well, you are familiar with the other experts in the case; aren't you?

A. I'm sorry. When you say "familiar with" --

Q. Do you know who tobacco has hired as experts in this case?

A. I have -- I do not know that I know all of their experts.

Q. You don't know that. All right. So as you sit here today, you don't know whether or not tobacco is going to suggest to the Court what the appropriate number for funding a cessation program should be if the plaintiffs prevail on liability?

A. Well, it seems to me there are three things that have to happen.

Q. Okay.

A. One is there has to be a numerical estimate of the class size, there has to be a definition of an efficacious program, and there has to be a cost estimate produced for that program that the Court finds credible.

Q. Well, I agree.

But so what you're telling me is you're not going to offer any such evidence on those three things?

MR. STERN:

Let me just object. Dr. Long will give any opinions that the Court wants to hear that are within his expertise.

MR. BRUNO:

Not if they're not in his report, he's not.

MR. STERN:

Well, take that up with the judge. I mean, --

MR. BRUNO:

You take that up with the judge. Are you telling me that I don't have a right to know what his opinions are now? Please.

MR. STERN:

No, of course not, Joe. But your questions --

MR. BRUNO:

Of course not?

MR. STERN:

Of course, I'm not telling you that. Your questions are so overbroad.

EXAMINATION BY MR. BRUNO:

Q. All I want to find out, Doc, is real simple, okay? You've attacked Burns. That's fine, that's fair, all right? But you do recognize that we might win this case; right?

A. That's a possibility.

Q. Okay. It's a possibility.

And then there will be a necessity to determine how much money tobacco should pay to fund cessation. So I'm trying to find out are you going to offer an opinion as to how much money tobacco should pay to fund cessation? You've given me the three methodologies -- I'm sorry, the three things that have to be done. But tobacco hasn't asked you to do that?

A. Currently, tobacco has not asked me

to do that.

Q. But you recognize that in order to accomplish the work of determining the amount of money, somebody's got to do it?

A. That's correct.

Q. That's correct.

A. And if --

Q. And it can be done?

A. -- liability were found and a class size were established and a -- the substantive content of a program were specified, and I were then asked to give an estimate of the cost of that program, I could do that.

Q. You could do that.

Okay. Now, why couldn't you have assessed the class size, that is, up till now?

A. To the best of my knowledge, no one has assessed class size now or at any previous time.

Q. Hasn't Dr. Burns?

A. Dr. Burns has defined a number of persons who have certain smoking characteristics. That's one element of the definition of the class, as I appreciate it, but certainly not all of the elements of the class.

Q. Well, how would you do it? How would you assess class size?

A. The -- First of all, I've not been asked to assess class size. Second, the -- many of the determinations that it seems to me go into class size -- And the questions are slightly different for cessation and for monitoring because we're talking about people with different characteristics for the two programs. Much of that has to do with things that epidemiologists and physicians would need to bring expertise to bear on.

Q. Well, are you telling me that there's no current information that will allow you to determine the number of Louisiana citizens who smoke?

A. I'm not aware that that piece of information is part of the class definition.

Q. It's not? The definition says Louisiana smokers.

A. Not as of today.

Q. Well, maybe you need to re-read it. But could you determine the number of Louisiana smokers today?

A. I believe that number can be

determined. I think we talked about that --

Q. Right.

A. -- in the earlier portion of the deposition.

Q. All right. And is there also information available that would identify the percentage of those individuals who want to quit?

A. I am not aware of that.

Q. You're not aware of any data at all on that subject?

A. Of how many of these people want to quit? I do not know that.

Q. Are you aware of any statistical data that would give an indication of what percentage of the current smoking population in Louisiana wants to quit?

A. As we sit here today, I don't know if that question was asked in any of the surveys we talked about last time. And that, of course, wouldn't relate to today's population in any event.

Q. Well, it wouldn't relate to today's population, you say. You're telling me that it wouldn't be a piece of information that would

assist in the assessment of costs?

A. That piece of information could be useful but it wouldn't be determinative.

Q. When you say "determinative," what do you mean? You mean you want to get the costs down to the penny? Is that how you would do this program?

A. I didn't know we were talking about costs. I thought we were talking about class size.

Q. Well, class size relates to cost, doesn't it?

A. Right now we were talking about determination of class size.

Q. Well, let's back up.

Because what you said was in order to get to the cost, you had to determine class size and the content specified in the cost of that service; right?

A. That's correct.

Q. And then after that, it's multiplication --

A. By and large.

Q. -- right?

I mean, it's not terribly

complicated stuff. How many people --

A. It's going out and assessing --

Q. Right.

A. -- costs for component parts and looking at volumes and a number of other things.

Q. All right. And when you're doing costing for groups of people, do you need to know the number of people who want to quit with absolute precision so that you have identified every single human being that wants to quit versus every human being who doesn't want to quit? Do you need that kind of precision in order to assess the costs?

MR. STERN:

Let me just object to the extent it calls for a legal conclusion because the class is the class. I mean, you can ask him if you want to estimate the number of people who desire to quit, but that wouldn't necessarily be the same as the people who fit this class definition.

MR. BRUNO:

That's totally inaccurate. And you're talking about your legal

conclusion. That's your own personal legal conclusion, which has no place in this deposition.

EXAMINATION BY MR. BRUNO:

Q. I'm asking you. I mean, you do this in your work at Tulane University. You assess the costs of programs; don't you?

A. Yes.

Q. I mean, you have, in fact, done that. And you, when you are assessing these costs, you don't go out there and identify every individual person who is going to avail themselves and then do a mathematical calculation that calculates it to the penny? You do cost estimates; don't you?

A. That's correct.

Q. All right. So you can do a cost estimate for a cessation program for the citizens of Louisiana based upon data that exists right now; can't you?

A. Some of the data which we have discussed would help in making that estimate. There are, you know, other questions, some of which I believe to be legal, about membership in that class.

Q. Like what?

A. For example, in one of the things that Dr. Burns was questioned about at some length was whether one could make an appropriate assessment of the number of people who were smoking on that 1988 date.

Q. But why would you have to --

A. And he approached it with an approximation of saying, "Well, if I start at age 25, I'm picking up most of the people who started smoking." But didn't have quantified -- quantitative data that would say what proportion that was picking up.

There are, you know, I believe, legal questions relating to causation that are not things I'm going to opine about.

Q. What do you mean, legal questions of causation?

A. If, for example, the tobacco companies were, per your hypothet, found liable --

Q. For a defective product.

A. -- then a question arises as to, among the smokers who would be potentially eligible for the class, how many are there

because of the -- how many are smoking because of tobacco company behavior as opposed to would have been smoking, anyway.

Q. What difference does it make why they smoke if the product is defective?

A. Well, as I say, that's a set of legal arguments that, you know, I'm not going to opine about. But I understand that there are issues that are going to be ultimately decided by the Court as to the various components that would determine class size. None of which have been addressed by Dr. Burns and which I'm not addressing, either.

Q. Right.

But you could, if you wanted to? In other words, you could give a realistic estimate of the cost of this program based upon the facts as you currently know them; couldn't you?

A. I don't know class size.

Q. And your testimony is that you couldn't even estimate it; right?

A. Not until all of those determinations have been made.

Q. Determinations as to --

A. It's still an estimate at that point.

Q. It will always be an estimate?

A. Right.

Q. I mean after you're all finished, it is still an estimate?

A. That is correct.

But until, you know, there are determinations that would, you know, say what proportion of, in the case of cessation, this 658,000 dollar -- this 658,000 person number are, in fact, meeting the class definition, then it doesn't make sense to talk about aggregate costs. We could talk about the cost of a modality for one person but you can't talk about programmatic costs.

Q. Sounds to me like it's lawyer driven and not expert driven then? You don't know what the definition says, so -- but you've got to wait for the lawyers to tell you who's in the class?

MR. STERN:

Objection. Argumentative.

EXAMINATION BY MR. BRUNO:

Q. Is that what you're saying?

A. I think the Court is the one who will ultimately determine who is and is not in the class.

Q. No, it won't. Who told you that?

(Whereupon a discussion was held off the record.)

EXAMINATION BY MR. BRUNO:

Q. Who told you that the Court will determine who's in and who's out of the class?

A. That is, in part, an assumption on my part because you told me that the Court wrote the class definition.

Q. The purpose of which was to allow people to read it and determine for themselves if they're in the class? Did anybody tell you that?

A. No.

MR. STERN:

Did anybody tell you what?

MR. BRUNO:

That that was the purpose of the definition: For people to read it in order to assess whether or not, in their own view, they're in or out of the class?

MR. STERN:

Objection to the form.

THE WITNESS:

I'm sorry. Okay. You're talking about potential people -- people potentially in the class?

EXAMINATION BY MR. BRUNO:

Q. Well, let's get down to cases, Doctor. I mean, we can play games, I guess, all day or not. But let's be realistic. People who smoke, who want cessation, who are Louisiana residents, are you telling me that you can't figure out how many there are of those people based upon what you currently know? There's no way to do that?

A. There's a way to estimate that, but that's not what I understand the class to be.

Q. Okay. There is a way to estimate that. How do you do that?

A. Even though it's not the class?

Q. That's what your lawyers are saying and I'm disagreeing, so I'm not going there. I'm saying assume for the purpose of the question Louisiana smokers who want to quit, they're in this class. Is there a way to identify how many of them there are? "Yes" or

"No"?

MR. STERN:

So -- First, objection to the form. It's argumentative. But the question is just current smokers who desire to quit, no other criteria?

MR. BRUNO:

There are no other criteria. But, you know, I'm not going to argue with you, Counsel. There are not.

EXAMINATION BY MR. BRUNO:

Q. But go ahead, Doc.

A. If that were the class definition, current Louisiana smokers who desire to quit, one could make an estimate of that number.

Q. All right. And then you could determine the cost of the cessation services or at least the content of the program that was being offered?

A. If we had a specific set of services and a basis for participation rates in the different modalities, then we could begin to estimate the cost of that service per person.

Q. Okay. Now, what would you use as

the basis for your participation rates? Where would you go to get that?

A. Because we are talking about participation rates in a program that does not exist --

Q. Right.

A. -- as opposed to existing participation rates --

Q. I understand.

A. -- then someone who had practical experience in a comparable program that could point to empirical measurement from that program could bring that information to the table.

Q. Right.

And the -- let's see -- the best person in that position would be Dr. Burns in view of his experience?

A. I do not know that.

Q. Well, in view of his experience in California, it's highly likely that that would be the guy to talk to; wouldn't it?

MR. STERN:

Objection. Lack of foundation.

A. Well, that would be one piece of

information. And if you believed that behavior of --

EXAMINATION BY MR. BRUNO:

Q. Californians?

A. -- the people who live in California is predictive of the behavior of people who live in Louisiana, then you would be closer than if you didn't believe that.

Q. And do you have any scientific data that would suggest that the smoking behaviors of the people of California are so substantially different from the smoking behavior of the people of Louisiana that that data might not be predictive in any way?

A. Well, there will be statistical data that would allow some comparisons between California and Louisiana. But it's certainly more than simply smoking behavior. It's not the smoking behavior; it's the desire-to-quit behavior that is relevant here.

Q. Okay. Do you have any information that would suggest that the desire-to-quit behavior of Californians is different from the desire-to-quit behavior of Louisianians?

A. I don't as we sit here.

Q. Okay.

A. I know that there are very different demographic characteristics through the two populations.

Q. Are you aware of any other states that have smoking-cessation programs in place?

A. As states?

Q. As states. As in tobacco control like Florida or like Massachusetts?

A. I'm not personally aware of Florida, but I believe I've read somewhere that Massachusetts does have a program.

Q. Right.

And are you aware that Dr. Burns is closely associated with the Massachusetts program as well?

A. I don't know that I was aware of that.

Q. Okay. All right. Now, --

THE VIDEOGRAPHER:

I need to change videotapes. Going off the record at 3:37.

(Whereupon a brief recess was taken at this time from 3:37 o'clock p.m. to 3:41 o'clock p.m.)

THE VIDEOGRAPHER:

We're going back on the record at 3:41.

EXAMINATION BY MR. BRUNO:

Q. All right. Doctor, I've got before you the -- Well, what exactly have I got before you? I'm not about to characterize it. It was attached to a letter that I got --

A. Yes.

Q. -- dated April 5. What is it?

A. It's a portion of what was marked as "Long 3."

Q. Okay.

A. All right. And it's the portion that I'm responsible for.

Q. All right. But, I mean, what is it? What is the series of pages?

A. This is a hard copy printout of some spreadsheets that I constructed with regard to the cost of monitoring services.

Q. Okay. All right. What's your bottom line on those sheets?

A. Well, there are lots of bottom lines.

Q. Oh, there are? I couldn't figure

that out. Is there not -- There's more than one bottom line?

A. There's more than one bottom line in both the literal sense of total costs.

Q. Okay.

A. And, also, in terms of conclusions.

Q. Okay. Well, let's take them one at a time then.

A. The other thing that is attached is, in addition to the spreadsheet, is simply a list of --

Q. Reliance materials?

A. -- reliance materials for the spreadsheets.

Q. Okay. All right. So why don't we take one bottom line at a time.

A. Well, first of all, there are two alternative sets of sheets, one of which is predicated on -- Well, let me back up. Let me say what's in common to the two sheets.

Q. Okay.

A. Both of the sheets --

Q. Forgive me. You know what we ought to do since you're doing that? Let's mark them separately, in globo. So "5" will be on, I

guess, the left stack and "6" will be on the -- And that will allow you to further identify the stacks.

(Whereupon the documents as described above were marked as "Long Exhibit Number 5" and "Long Exhibit Number 6.")

THE WITNESS:

All right. You want that separate?

MR. BRUNO:

Sure. Why not? She made out all these numbers. I hate for them to go to waste. She worked so hard on that.

(Whereupon the document as described above was marked as "Long Exhibit Number 7.")

MR. BRUNO:

Okay. All right. So we've got "Long 5," "Long 6" and "Long 7."

THE WITNESS:

Right.

MR. BRUNO:

All right.

THE WITNESS:

"5" and "6" are the spreadsheets and

"7" is the reliance.

EXAMINATION BY MR. BRUNO:

Q. Okay. And you were telling me what the similarities were between "5" and "6."

A. Okay. Each of "5" and "6," for their internal purposes, take the numbers that Dr. Burns set forth in his spreadsheet for class size and age distribution within that class size. And both sheets use Dr. Burns' program of medical monitoring services as he altered it in the course of his deposition.

Q. Okay.

A. And both of the spreadsheets look at the cost to the program per test that was used by Dr. Burns in his original spreadsheets.

Q. Okay.

A. And the cost per test that would be the amount, equal to the amount paid by the Medicare program for these services to its beneficiaries. And as a third data point, an amount, a cost-per-test to the program equal to the payment in Louisiana for the Medicaid program purchasing these services for its beneficiaries.

Q. Okay.

A. Both sheets also, as an additional alternative with respect to spiral CT scanning only, do a cost estimate based on the direct purchase and operation of the scanners as opposed to buying CT scans from existing providers.

Q. You mean buying the hardware instead of the service?

A. Buying the hardware --

Q. Right?

A. -- and the other resources required to deliver scans. That is, hiring people as well as buying machines.

Q. Okay. And have you got administration in that one?

A. I do.

Q. Okay. And --

A. And I have administration both in terms of administrative costs associated with running the scanners and both sheets also have administrative costs for the overall program.

Q. Okay. So the running and the program -- The program, that would include the recordkeeping and the like; right?

A. Yes.

Q. Okay. All right.

A. The two sets of sheets differ in that one set uses the 35 percent participation rate testified to by Dr. Burns as his original estimate concurred in by the panel of Louisiana physicians with whom he worked. And that's "Long 5."

And "Long 6" uses the 100 percent participation rate which was contained in his report that he testified to was based on instructions from counsel.

Q. Okay. Good.

So it sounds to me like you're going to have, you're going to have -- well, you'll have a bottom line for the 35 percent and you'll have -- well, actually, you have two bottom lines for the 35 percent, one with buying the machines versus buying the services; right? And then on the hundred percent, you'll have two bottom lines?

A. Well, associated with the difference between buying the services and producing the services, if you would.

Q. Got you. All right.

A. But then for the other services,

other than CTs, we have priced out at Medicare rates, which Dr. Burns had testified in his deposition was what he intended to use; and Medicaid rates, which he also testified in his deposition was another program that could be looked to.

Q. Okay. So --

A. So there's Medicare rates, Medicaid rates, with and without buying the scans versus producing the scans.

Q. All right. So with the -- Let's go to the hundred percent, okay? What is your bottom line buying the services of the CT under the three cost evaluations? You made it three? Didn't you say Medicare and Medicaid? Or is it two?

A. Right. If we bought the scans from existing providers --

Q. I suggested buying the services but we'll take that first. We're buying the equipment now?

A. Okay. That's different.

Q. Never mind. I just want to follow you. You're buying the service?

A. You're buying the service --

Q. All right. I'm going to write that down. Buying the service.

A. -- as opposed to producing the service.

Q. Okay. All right.

A. If we were buying scans, scan by scan --

Q. Got you.

A. -- and paying the same price that Medicare pays --

Q. Right.

A. -- in Louisiana, and what I've done here is I've used the rate that Medicare pays in New Orleans. They also pay a different rate outside of New Orleans, which is slightly lower. But I've used the higher rate rather than try to say how many were in New Orleans and out of New Orleans.

Q. All right.

A. So these are at the higher of the two possible Louisiana Medicare rates. And this is for a single year.

Q. One year.

A. For one year.

Q. Got you.

A. Including programmatic administrative costs would be about 202 million dollars.

Q. Okay. Two hundred and two million.

A. Right.

And as I say, that's slightly overstated to the extent that it's using New Orleans rates for the entire state.

Q. I understand.

Okay. Now, do you also have a Medicare?

A. Medicaid.

Q. Medicaid.

A. That was Medicare.

Q. Oh, care. Okay. Medicare. So what's the Medicaid rate? Is there a big difference between those two?

A. There's a substantial difference.

Q. All right. What's the different number there?

A. The comparable number for Medicaid -- and these are statewide rates -- would be a little over 161 million dollars.

Q. All right. Now, we're talking about the same services; right?

A. Yes, sir.

Q. So how do you account for that big difference in cost between --

A. Well, --

Q. I mean, that's -- gosh -- that's a 41 million dollar difference.

A. In payment.

Q. In payment now. That's not the cost of service. That's what these programs will pay you; right?

A. If I'm a provider of these services and one of those programs' beneficiaries seeks service from me, that is what I would receive from those public programs.

Q. All right. Now, in fact, not every healthcare provider accepts those payments; right?

A. With respect to Medicare, virtually every provider who provides services covered by Medicare, in fact, participates in the Medicare program.

Q. All right. So that nobody gets rejected? I don't -- It doesn't matter who you are, you go to a doctor, you give them your Medicare card, they'll give you the service;

right?

A. The only -- That is a generally true statement, yes.

Q. A generally true statement.

Now, and the way that -- And you know this because you are in an institution that has to deal with costs; right? Tulane, that's where you are; right?

A. I'm sorry. I know this. What was the "this"?

Q. You know the fact of the payments by Medicare? I mean, you deal with that every day, this business of whether Medicare will pay the institution and so forth?

A. It's not because I -- my employer is Tulane University, which happens to have a segment of the university that participates in the Medicare program; it's because I teach a course in payment systems --

Q. Right.

A. -- that I am most familiar with this. Not because I'm over at the hospital looking over their shoulder at their checks for Medicare.

Q. Oh, I was wrong. I thought that

you had something to do with that.

Well, so let me ask you this. Does Medicare reimbursement cover the cost of the service at Tulane?

A. Yes.

Q. Okay. Does the Medicaid payment cover the cost of the service at Tulane?

A. Yes.

Q. Does it provide an appropriate profit margin?

A. It depends on who you ask and what you mean by "appropriate."

Q. Well, let's see. How do I tackle that one then? Is Tulane satisfied with the current Medicare reimbursement?

A. I think that if you ask any provider, individual or institutional, in this or any other state if they are happy with their payments from Medicare, they would tell you that they would like them to be higher, that they're not happy.

Q. But they survive?

A. But they, in fact, participate in the program, they deliver care, they get paid, and they do it again next year.

Q. Well, and, in fact, they get more money for the same services from insurance reimbursements; right?

A. It depends on the insurance reimbursement. Remembering that there are, in this universe, 30 to 40 thousand --

Q. Different carriers?

A. -- different things that you can get paid for, you know, clearly, there will be some things that you will be paid more money from most private insurance than you would be paid from Medicare or Medicaid. But there are ones that go the other way, too.

Q. Well, I mean, let's be straight about it. If the institutions were required to subsist on Medicare only, in other words, that's their rate of reimbursement, if it was across the board the same way, could they survive?

A. Most institutions could survive. There's data, for example, that shows what we call Medicare margins, which is how much money do you make on just your Medicare patients.

Q. Got you.

A. And for the vast majority of

hospitals, for example, in the United States, those are positive numbers.

Q. Well, why is it not everybody?

A. The few that are negative Medicare margin tend to be very small public hospitals in rural areas --

Q. Rural areas?

A. -- in the midwest and far west.

Q. Okay. Would that translate into the rural areas of this state as well or not?

A. Generally not.

Q. Okay.

A. In the Medicare program.

Q. Because we're populated enough in Louisiana where you don't really get that kind of rural, that is, the Wyoming kind of ten people --

A. Exactly.

Q. -- in 50 square miles kind of rural?

A. Yeah, where you're talking about a 25-bed hospital.

Q. I understand.

Okay. Now, let's talk about the Medicaid. Is that true of Medicaid as well?

Could the hospitals survive on the Medicaid level of reimbursement if that's all they got?

A. In Louisiana, the answer is "Yes." It is not necessarily true in every state. Because Medicaid, as you know, differs state to state in the definition of its programs, who's in it, what's covered and what the payment rates are.

Q. But not everybody -- Now, as I understand Medicaid -- and I don't know this stuff as well as you do, obviously -- but Medicaid is a voluntary program?

A. It's voluntary for the state.

Q. Okay.

A. I mean, no state has to be in the Medicaid program. So it's, first of all, voluntary whether you have a Medicaid program or not.

Q. But doesn't the provider have to participate? I mean, he doesn't have to -- that is, the healthcare provider doesn't have to provide health care to the Medicaid recipient?

A. Again, depending on the state.

Q. How about here?

A. In Louisiana, you can choose to be a Medicaid provider. If you choose to be a Medicaid provider, then you have to take all the Medicaid that show up.

Q. Right. You've got to take them all. But as I understand it, you don't have to be -- you don't have to choose to be a Medicaid? You can say, "No, I'm sorry, I'm not taking Medicaid -- period"?

A. That is legally permissible in Louisiana.

Q. That's not true of Medicare; right?

A. Yes, that's true of Medicare as well. No one has to be in the Medicare program as a provider.

Q. Oh, I see.

A. You have to apply, you have to get a provider number, you have to be licensed and accredited and a whole bunch of other hoops to jump through to get a provider number. You don't have to do that.

Q. Okay. I got you.

Now, as an expert, would you choose the 161 number or the 202 number or would you blend it or average it to be -- to make sure

you had enough money to fund the program?

A. When you say --

(Whereupon a discussion was held off the record.)

THE WITNESS:

When you say would I choose --

EXAMINATION BY MR. BRUNO:

Q. Yes.

I mean, you've chosen two numbers, okay? You've got a Medicare number, you have a Medicaid number. As an expert, which number would you recommend? I mean, I'm not suggesting the hundred percent participation business. But, I mean, if you were down to this point and the judge was going to say, "Well, Doctor, what number should be my -- the number in order for me to properly fund the program so that it, you know, it works?" Knowing that a year from now we can always revisit and we can change these numbers?

A. Correct.

MR. STERN:

Well, just quickly for the record, there are other things in the program that Dr. Long isn't addressing.

But subject to that, go ahead.

EXAMINATION BY MR. BRUNO:

Q. And guess what? I wasn't asking about the other things that you weren't addressing. I was asking about what you were addressing, which was the Medicaid/Medicare.

I mean, these are dramatically different numbers. We're talking about 40 million dollars. It's a 25 percent difference. So that's why I'm trying to figure out, you know, what --

A. Twenty percent, actually.

Q. Oh, 20? Well, where I come from, you know, you want to make it as big as possible.

A. In part, it would depend on the Court's philosophical construct of the program. From an economic perspective, it would be my recommendation to the Court that if these were the volumes and these are the volumes only if --

Q. They're assumptions. Right. We've said that.

A. If we were talking about this kind of -- this number of tests and we were talking

about buying them service by service, which is what we're doing so far, then as an economist, my position would be that whatever the program entity is should get the benefit of the bargain to deliver this volume of demand. And that the economically appropriate funding would be that amount of money which would be sufficient to entice the producers of these services to sell to the program with a sufficient margin or contribution to keep them in the program.

Q. Right.

A. And it would be economically more favorable for them to, in fact, deliver care to these people than not to deliver care. That number is, in my opinion, in Louisiana for these tests something in the vicinity of the Medicaid number because providers, in fact, as we speak, are delivering these services to Medicaid beneficiaries. And if they didn't want to, they wouldn't have to.

Q. Right.

Well, it sounds to me, though, like it could be a negotiated number.

A. Yes, it could.

Q. And it ought to be? Shouldn't it

be, really? I mean, we could --

A. One could negotiate it, one could put it out for bid.

Q. Right.

A. I mean, there's a variety of mechanisms that one could pursue. But, basically, you're saying that some central entity responsible for a monitoring program would go into the marketplace in whatever form and say, "We stand ready to deliver 'X' hundred thousand physical exams or spirometries" or whatever. "And we'll either sit down at the table and negotiate with you or we will piggyback on Medicaid rates or we will put it out for competitive bid" or whatever.

But it would be somewhere in that vicinity because the market's already telling us that they'll do it for this.

Q. Well, it's a little bit different market, though; isn't it? I mean, because we're not talking about healthcare delivery in the usual sense. In this particular instance, we've got to keep track of the medical record of the particular people so that it all connects.

As I understand the program, you have a physical examination at a certain age, and then you've got something that may happen five years later or ten years later, and all those things have to connect together. So that you just can't give the service and walk away as you would do perhaps in certain institutions. There's got to be a follow-up record.

A. Well, I think we're segueing into programmatic administrative costs here.

Q. Right.

Which are not in this?

A. Which are in this in the numbers that I gave you over and above the costs of the individual tests.

Q. All right. So what's the gross number? You gave me a net? Did you give me a number which included administration?

A. I gave you a number which included administrative costs.

Q. All right. So I'm wondering, though, whether or not that fact -- Administration is the person who's going to have to collect the medical record and keep

it somewhere for the use of the subsequent provider giving the test, given the appropriate age?

A. (Witness nods head affirmatively.)

Q. The healthcare or the service provider is going to have to access that information and have it either delivered to them or whatever in order to compare the numbers or compare the information. Would that add to the cost of the program?

A. Well, I think there are two kinds of costs that you're actually alluding to. One is administrative costs at the level of the provider generating the paper, putting it in the medical record, et cetera. Maybe not paper anymore, maybe electronic.

Q. Maybe it's electronic.

A. Right. Whatever.

Q. But it's got to go to some central depository somewhere.

A. So there is some cost to the caregiver --

Q. Right.

A. -- of doing that. And that is included in the per-test payment.

Q. All right.

A. Just as it would be for the Medicaid or Medicare programs where similar recordkeeping by -- at the level of the provider has to happen.

In addition to that, there is a programmatic administrative cost, which is the maintaining of that information as well as disbursing money to the caregivers --

Q. Well, yeah.

A. -- that is at the programmatic level. And that is included in the numbers that I gave you.

Q. But this is a different kind of a program in that there is a need for some centralized file or recordkeeping of each of the participants, which is not usual; right?

I mean, Medicare or Medicaid, they don't have some central repository of the medical records of all the participants? It's quite the opposite. Each healthcare provider keeps their own medical record; right?

A. That's correct.

Q. All right. This is a little bit different. You've got to have some central

repository of all of the participants' medical records so that can be read?

A. Well, it's not clear to me that, particularly in an age of electronic record-keeping, that it's a central repository as opposed to records which are accessible.

Q. That's even more cost.

A. Not necessarily.

Q. Well, just walk through it with me. You know, at age 50, let's be realistic, you know, the doc says it's time for the CT and he wants to see about the physical examination that took place at age 25 and maybe the exercise stress test which took place at this age or the cholesterol which took place at age 30.

I mean, you know, I mean, he may want to see all that stuff. And either, A., it's got to be in some central repository or, B., he's got to go get it. Which, to me, it would be more cost-effective to have some central repository.

A. Well, that level of specificity of the mechanics of the program is not something that I've seen laid out by Dr. Burns or anyone

else at this point. I'm merely suggesting that we have the technology in place now that, subject to certain privacy constraints, that, you know, Provider A can access the medical records of Provider B with the appropriate code.

Q. Right. Right.

A. And/or you can pull something up, you know, over the Internet. And that that technology, particularly if this program were to go on a few years as, you know, plaintiffs contemplate, is completely within the realm of what we would expect to be done.

Q. Okay.

A. Particularly in a fairly constrained geographic region for a defined population.

Q. Right.

Now, given the fact that some people may not accept these payments, regardless of whether it's the Medicare or Medicaid, if you were going to put in place a program which was going to guarantee the service, in other words, the person had the right to the service regardless of its cost,

then wouldn't it make some sense to either contract for or do something to make certain that these prices were going to be acceptable by the healthcare providers?

A. Yes.

Q. Okay. And your opinion is that, well, Medicaid is paying this sum of money, so it's likely that these healthcare providers would pay -- I'm sorry -- accept the same amount of money?

A. Or something in that vicinity.

Q. All right. Well, let me ask you a really stupid question.

If Medicaid -- and I'm asking this question as a taxpayer now -- but if Medicaid is paying 41 million dollars less than Medicare, why doesn't Medicare cut its reimbursements to the Medicaid level?

I mean, I would. You just said, man, get the bargain for the people here. And since we're now, since it's April the 17th --

A. I think we have moved at this point into a political question.

Q. Well, we're talking about the same issues. It's provision of healthcare services.

It may be political. But if it's political, it's going to be political for us, too.

A. Well, the Medicaid program rates are set through a political process in this state that occurs in Baton Rouge. Medicare rates are set through a political process that occurs in Washington D.C. Medicare rates, although they vary geographically, spring off of a base rate which is determined nationally. And the politics of that rate involve the American Medical Association, specialty societies, hospitals, a whole variety of national associations and large players. And the dynamics of that are simply different. The funding is different. It's a trust fund. It's an entitlement. There's 39 million beneficiaries --

Q. All right. Forgive me for stopping you.

A. -- who have a lot of clout.

Q. Yeah, I don't mean to interrupt you. But when you said it's a trust fund, it's an entitlement, which one is which?

A. Medicare we're talking about.

Q. All right. Medicare is an

entitlement and it's a trust fund?

A. For most of the services that we're talking about, right.

Q. Yeah.

Interestingly, so would this one. This one would be a trust fund and it would be an entitlement.

A. This one could meet those legal definitions.

Q. Okay.

A. Medicaid, by contrast, is a program which is generally labeled a welfare program that, although it has to comply with certain provisions of federal legislation in the enabling statute, creates huge discretionary options for each state, including payment.

The political clout of the people who receive services in the Medicaid program is very different than the political clout of those who receive Medicare services. And for that and a wide variety of other reasons, you get significant rate differentials.

What's in common, however, is that no program and for any substantial period of time can pay providers less money than it costs

them to deliver the service or the program will crash and burn.

Q. Okay. How many -- Do you have any information about how much -- I'm trying to -- and I may not be articulately asking this question -- but, you know, how many dollars are paid through Medicaid in Louisiana versus how many dollars are paid through Medicare?

A. I do have access to that information, but I can't tell you off the top of my head as I sit here.

Q. Is there a relationship between the two? I mean, I don't need the precise numbers. For example, is Medicare like three to one Medicaid or twice, two to one or --

A. I would -- My recollection is that the number of people covered in the programs is relatively close in Louisiana. And based on that, it would be my educated guess, as we sit here, that Medicare would spend more money because of the different characteristics of the population in Medicare compared to Medicaid.

Q. Is there overlap?

A. There is.

Q. Yeah, I seem to recall that.

There's overlap meaning a person could be a Medicare eligible person and, also, a Medicaid eligible person?

A. Yes.

And I don't know that number in Louisiana. But, nationally, there are about five million people who are in both programs simultaneously.

Q. Okay. All right. Now, the next thing you did was you carved out or -- you didn't carve it out -- you just got a different method of providing the CT, that is, you bought the equipment. So what number -- how does that change your numbers, if it does at all?

A. Okay. Based on some things that were in Dr. Burns' deposition where at one point he suggests, you know, you may, when he's talking about CT scanning, you may need to designate some facilities and put particular capacity, either fixed or mobile, in parts of the state to -- where the population is --

Q. Right.

And, also, generate consistency in reading the scans?

A. Yeah.

So what I did, based on that proposal, was took a look at a range of scanner capacity, how many scans can one scanner produce, looked at the population of Louisiana by what are called state planning districts, which are geographic segments of the state, and distributed scanners geographically, proportionate to those population areas, putting enough scanners in each district to, in fact, deliver scans for the number of people that Dr. Burns had suggested. And I did that for a range of capacity, how many scans can you do per hour.

I also looked at a range of purchase prices for scanners, which was consistent with what Dr. Burns testified to and, also, my own independent investigation.

Q. All right.

A. And ran from five hundred thousand dollars up to a million dollars of purchase price for the scanners.

Q. All right. So just to clarify, in the one instance where you did go out and check Dr. Burns' numbers, they were right?

A. Yes.

What I found were purchase and lease agreements with respect to spiral or helical CT fell within that range that he had opined to in his deposition.

Q. Okay. All right.

A. And I then took the other resources in terms of staffing that were put forth in one of the presentations at one of the Cornell conferences that Dr. Burns had referenced, and then added in some of the ordinary business expenses of square footage and utilities and insurance and the rest.

Q. The rent?

A. Yeah. The square footage is lease, lease cost.

Q. Okay.

A. And that -- all those costs are laid out on one of the spreadsheets.

Q. Okay.

A. Along with, you know, the technical personnel that came out of the Cornell presentation, the techs, clerical personnel who would make appointments, keep track, put the data in. Plus, employing radiologists to do the reads based on the national average, the

number of images read by a radiologist, and put all that in, and costed it out with Louisiana costs.

Q. All right. Did you include somebody to sit down with the patient and explain the results?

A. It was my appreciation that if there were results that needed to be explained, that -- which I took to mean adverse results --

Q. Oh, I see.

A. -- that this would be referred to someone who would be involved in a treatment or a further diagnostic set of procedures. That if we got a CT scan that gave us pause --

Q. Right.

A. -- an abnormality --

Q. Right.

A. -- that as I appreciated the program, that person would then move into a different set of services that might be other diagnostic procedures, biopsy perhaps, or treatment.

Q. Right.

A. Which is not covered by monitoring.

Q. All right. I'm with you.

I just don't understand how you -- There's got to be at least a cost for getting them into that program. You got to tell them something or tell them where to go or even a letter.

A. Well, there may be such a cost. But that's not one of the things that Dr. Burns set out as a component of his program. So I took his definition of the monitoring program.

Q. All right.

A. And, of course, that definition is a moving target.

Q. I understand.

All right. So does that make the numbers go up or down?

A. I'm sorry. Does what?

Q. Does that make your bottom line numbers go up or down, the use of -- I'm sorry, buying the equipment versus buying a service?

A. I have a range of costs associated with purchasing and operating the scanners. Let me back up and identify on the third page of the spreadsheets, there is a line item which specifies what just the CT scans would cost if you bought them scan by scan.

Q. The service. So you would eliminate that, obviously?

A. Right. So you back that out and substitute this.

Q. And that's why I said does this make the overall number go up or down?

A. It makes the overall number go down. And, again, depending on the cost of the scanner and the capacity. If everything else is done at Medicare rates and you own and operate the scanners, then the total cost ranges anywhere from 100 to 124 million dollars for a year.

That, by the way, loads the purchase price, the entire purchase price of the scanner into that year, even though ordinarily the scanner would last several years.

If everything else is purchased at Medicaid rates, you own and operate the scanners but you buy everything else at Medicaid rates, it makes the numbers run anywhere from 96 million to 120 million dollars.

Q. All right. And that's for -- So

that includes all the other services on top of the bought equipment?

A. Yes.

Q. Okay.

A. That's correct.

Q. All right. Okay.

A. That being at the hundred percent participation.

Q. All right. Now, how do these numbers differ from Dr. Burns' numbers?

A. Dr. Burns' numbers run -- And I don't think we footed them separately on the spreadsheet, so let me just see if my recollection is correct quickly here.

Dr. Burns' numbers run approximately 345 million dollars.

Q. Okay. So easily less than half?

A. Easily.

Q. Okay. All right. Now, what happens when you go to the 35 percent? I mean, obviously, you just cut it by 65 percent?

A. Approximately. There's some differences because of fixed and variable costs. You -- You know, a scanner has a certain amount of capacity. In some parts of

the state, it may not be completely busy but you got to have one there. There's not quite enough population to keep it a hundred percent occupied but you've got to have one.

Q. You've got to maintain it?

A. And you've got to maintain it.

Q. All right.

A. And so there are some things that are not linear in this. But roughly speaking --

Q. Yeah.

A. -- you're talking about a two-thirds reduction.

Q. If you have some concern about the usage, then you probably ought not buy the equipment, I would imagine, huh?

A. It depends on what percentage of the capacity you're using. It would not make sense to put a scanner out there and use it three hours a week.

Q. Right.

A. But that doesn't mean you got to use it 50 hours a week.

Q. Right.

So in the urban areas, it might

make sense to buy it; but in the rural or more rural areas, it might make sense to buy the service?

A. What we did for this analysis was where -- Let me give you an example. In -- Well, generically, we have two adjacent planning districts. And doing the arithmetic, one planning district needs 1.3 scanners and the one next to it needs 1.3 scanners.

Well, you don't put two in each place. You put one in each place and then you have a mobile scanner. That, as Dr. Burns suggests, it spends half the week or one week here and one week over there.

Q. Right.

A. So you get pretty close to having capacity. And if you do that, then the purchasing is the lower cost alternative.

Q. Okay. All right. So what's the difference in the numbers?

A. Okay. For buying the scans, not buying the scanners, in other words --

Q. Just like we did last time.

A. -- back to the original numbers --

Q. Yeah. Medicare?

A. -- Medicare would be about 71 million dollars.

Q. Okay.

A. Medicaid, about 57 million dollars.

Q. Okay. And then buying --

MR. STERN:

I'm sorry. This is at which participation rate?

THE WITNESS:

Thirty-five percent.

MR. BRUNO:

Thirty-five percent.

MR. STERN:

Okay.

EXAMINATION BY MR. BRUNO:

Q. And then if you bought the equipment?

A. And then if you bought the equipment and bought everything else at Medicare rates, it would range from 38 million to 46 million.

Q. Okay. Why is there -- Oh, that's because you had ranges. I'm sorry.

A. That's because I have ranges in the scanner.

Q. You had ranges before. Okay.

A. And if you bought everything else at Medicaid rates, it would run from 36 million to 45 million.

Q. Okay. All right. Now, why did you undertake this exercise?

A. The purpose of this exercise was to -- If one takes at face value Dr. Burns' population and battery of tests at the indicated ages and all of the rest, he had indicated almost in passing in the first part of his deposition that his $328 price for a CT scan had come from Medicare.

In the most recent part of his deposition, he suggested that more than the CT scan number was consistent with Medicare but you could also look at Medicaid. When -- After I got the first piece of the deposition, you know, I popped in to the Medicare data and didn't find $328, in fact, found a number substantially lower than that.

Q. Wait. What were you looking at, though? I mean, a CT scan is not really -- hadn't been out there that long.

A. Medicare has a rate.

Q. They have a rate for the spiral CT?

A. For a CT scan without contrast, which is what they currently pay -- If somebody in New Orleans does a CT scan, a spiral CT scan right now, Medicare will pay, you know, if it's medically necessary, Medicare will pay for it, then that's what they will pay for it. They don't have one rate for a spiral and then a different rate for whatever nonspiral is. But they'll pay for it.

And maybe they should have a different rate, maybe they will have a different rate, but right now you get paid to do one. And that's what they pay.

Q. Okay. So we don't -- we really don't know about the difference between the spiral and the nonspiral scan?

A. Yeah. But what I did find out, as I did the purchase thing, is that the purchase prices --

Q. Are the same?

A. -- are basically the same.

Q. Okay.

A. The staffing is about the same.

So it looks like, you know, if I

were advising Medicare based on what I found in one state at this point, you know, I would suggest to Medicare that it doesn't look to me like they need a different rate.

Q. Right.

And you account for the difference in the cost of buying the service versus the cost of buying the equipment the profit that these institutions derive?

A. There would be two components to that difference: One would be the, what we call, the cost of the capital or the opportunity cost. Which if I am an independent private organization and I've got to come up with a million bucks to buy a scanner, then the million bucks has to come from someplace.

And maybe I'll borrow it from the bank or maybe I'll sell bonds or maybe, if I'm a for-profit entity, I'll ask my shareholders or partners to come up with the money. And they're going to want a return on their capital, not in the sense of profit, but for the use of money because they could have taken the same money and done something else.

Q. Right.

52434 8025

A. So part of it is a return on the capital.

Q. Which we don't have --

A. Which is not necessary here.

Q. Which we won't have here --

A. Right.

Q. -- because it's being funded by the --

A. Right.

Q. Okay.

A. And, in effect, that cost is -- still exists but it's borne by the people who are doing the funding.

Q. I understand.

A. And, therefore, they don't have to fund it a second time.

Q. Right.

A. The other component would be margin, which might be called profit if you were for profit and might be called excess of revenues over expenses if you're nonprofit.

Q. I understand. I understand.

A. But it still serves an economic purpose for the infinite life of the provider organization, that is, a renewal of its assets,

provisions for new technology, inflation, all the things why any ongoing institution needs a margin, whatever you label it. And that would be the second component.

Q. Okay. And, of course, there is no margin in your numbers?

A. That's correct.

Q. All right. So --

A. Because this is, you know, assuming a year at a time. And if you need more money next year because more people participated or because the technology changed, then there's more money next year. And if it's the other way, there's less money next year.

Q. How do your numbers compare, that is, when you compare the cost of the service with the cost of the equipment? We didn't do that analysis.

A. I'm sorry.

Q. Under Medicare utilizing the hundred percent, what was the number that you did back out of that 202 million?

A. I'm sorry. I'm not following your question.

Q. All right. Well, we took out the

cost of the CT service --

A. Right. Yes.

Q. -- and plugged into it the cost of the equipment. So what was your Medicare service number for CT?

A. For CT scans?

Q. Right.

A. Got you.

Q. In other words, I just wonder what those two numbers, how those two compare and contrast?

A. In other words, buying CT scans versus service by service.

Q. Right. Versus the equipment.

A. In the hundred percent participation was 126 million under Medicare rates and 90 million under Medicaid rates. And in the 35 percent, it was 44 million at Medicare rates and 31.4 million at Medicaid rates.

Q. So you don't really save that much under the Medicaid rates but you save much more under the Medicare rates?

A. I'm not sure what comparison you're making.

Q. Well, it just occurred to me that you were saving about 30 million using Medicare rates.

A. Between what and what?

Q. In your hundred percent.

That is, I understand you to say or understood you to say that about 120 million if you bought the service using Medicare rates? And then you saved about 30 million if you went and bought the equipment?

A. No, no, I haven't --

MR. STERN:

He just gave the Medicare and Medicaid comparison. You now want him to give the buying the equipment comparison?

MR. BRUNO:

Well, that's what I was asking for. That's why I got confused.

THE WITNESS:

Okay. I'm sorry. I got confused then, too.

EXAMINATION BY MR. BRUNO:

Q. Yeah.

No, the whole deal was whether we should go out and buy the equipment versus buy

the service, so I want to compare those two.
A. Okay. I think, I think I'm there.
MR. STERN:
Joe, correct me, what you now want to ask Dr. Long is what does it cost -- what does one year cost for CT scans only if you buy the equipment?
THE WITNESS:
Just CT scans?
MR. BRUNO:
Versus buying the service.
MR. STERN:
Right.
THE WITNESS:
Right. Okay.
EXAMINATION BY MR. BRUNO:
Q. I mean, that's our decision, so let's compare apples to apples.
A. All right. Let me give you the three numbers then.
Q. Okay.
A. At a hundred percent participation, if I buy service by service under Medicare, 126 million. If I buy service by service, Medicaid rates, 90 million. If I buy and operate the

scanners, somewhere between 25 and 49 million.

If we go to the 35 percent --

Q. All right. While we're there, so that --

A. While we're where?

Q. Well, while we're there, what's intriguing to me is that the margin and the cost of the capital is 76 million dollars under Medicare?

A. Providers are making a lot of money --

Q. They're making, well, --

A. -- providing CT scans.

Q. Forgive my French, but they're making a big pot of money providing CT scans?

A. Right.

Q. Seventy-two million dollars -- I'm sorry, 73 million dollars.

A. For this number of scans -- If, if there were a provider that was providing this number of scans to Medicare patients.

Q. Right.

Of course, the more scans, the more money they make?

A. Sure.

Q. So it's a little different deal, but --

A. Right.

Q. All right. Let's look --

A. And the volumes we're talking about here are much larger than we would see at any typical provider currently.

Q. All right. So let's look at the 35 percent.

A. Okay. The comparable numbers, 35 percent bought service by service at Medicare rates, about 44 million dollars. I'm rounding here to the nearest million. The numbers are on the sheets. Medicaid rates, service by service, 31 million dollars. Buy and operate the scanners, somewhere between 11 and 20 million dollars.

Q. So that's 24 million in margin and capital costs against Medicare?

A. Medi -- Against Medicare, yes.

Q. Medicare.

And 11 million in Medicaid --

A. Yes.

Q. -- in profit or margin, if you will?

A. (Witness nods head affirmatively.) Medicaid is not an unattractive program for many of the services that are covered.

Q. Okay. All right. Now, with regard to Dr. Burns' exemplar monitoring program, what did you learn in the, if anything, in the deposition that allows you to additionally critique the program?

A. Well, there were a variety of things that came up over the three days of transcripts that I reviewed that -- some of which we've already alluded to here. One was an explanation of the change through the evolution of his drafts in participation rates. And that, as I appreciated his testimony, that his best judgment was the 35 percent participation rate.

Q. Are you critiquing that?

A. And I believe that is a more reasonable participation rate than the hundred percent participation rate, as I think I testified to last time.

Q. I know. But that's not the question. The question is is that a good rate -- period? Is that a fair number, 35

percent?

A. I honestly don't know.

Q. Well, sure, you work for the other side and it's a lower number, I could say that I like it, too.

I mean, as an expert witness, Doc, come on, is that closer to the, you know, based upon your expertise, the right number or is it just a better number for your team?

A. No, it's a number that is more in line with participation rates that I'm aware of in other screening programs.

Q. Well, sure. No screening program is at a hundred percent. We talked about that last time.

A. Right.

Q. So to that extent, anything under a hundred is going to be more in line.

A. Yeah.

I think, as Dr. Burns testified to, this is pretty close to what has been seen in Louisiana for mammography screening. It's a little higher than what I saw with respect to a black lung screening program. You know, I don't have an independent judgment of

participation rates here. I can just say to you what I've said.

Q. Okay. So where do we go to get it? That is, the judgment with regard to participation rates, who do we talk to?

A. Well, I think who you already talked to.

Q. Dr. Burns?

A. Dr. Burns and the panel of Louisiana doctors that he relied on.

Q. Okay. That's fair. That's fair. Who are your colleagues?

A. Some of whom are my colleagues --

Q. All right.

A. -- some of whom are my competitors.

Q. That's right. Okay. All right. Did you find any other basis to criticize his population numbers, that is, the gross numbers?

A. The -- In his program as it was presented in his spreadsheets, which is something that I avoided that difficulty by here, you know, looking at a single year, partially on the -- what the Court has suggested that maybe that's how it would like

to proceed.

Q. Yeah.

A. But if one were looking at multiple years, I noted in the deposition that Dr. Burns acknowledged that he had not done the mortality calculations correctly. So that beyond the second year, his numbers are too big.

Q. Right. Yeah.

But just with regard to the year, though, were there any other --

A. Well, with regard to the year, the other things that we've already talked about --

Q. I think what you told me was if you used the CPC data, then that would be reasonable.

MR. STERN:

I don't think he was finished with his answer.

A. CPC?

EXAMINATION BY MR. BRUNO:

Q. Yeah, the -- Is that what it's called? I've got it right here. Current Population Survey.

A. CPS.

Q. I'm sorry, CPS. That's what I

screwed up. CPS data, you haven't -- that's the same opinion today; right?

A. Yeah, no change to what I talked about before.

Q. Okay.

A. But understanding the comments that we've made earlier today that although that may be an estimate of persons with certain smoking status, you know, we still have those other legal questions that I gather are still to be resolved.

Q. No, I guess I don't know what you mean.

A. That we were talking about causation and whether one might have smoked, anyway, regardless of the tobacco company behavior, et cetera.

Q. That sounds like something they told you, though. I mean, if it's a defective product, it doesn't matter why --

A. Well, like I say, I'm not going there.

Q. I totally lose you when you say that.

A. I'm not even going to go there.

Q. Because if it's a defective product and then -- I mean, you know, we -- there's no question but that cigarettes cause damage to people; right? I mean, even the defendants admit to that?

MR. STERN:

Well, let me just object to the form.

EXAMINATION BY MR. BRUNO:

Q. Isn't that right? I mean, that's what you understand to be the case with regard to the use of cigarettes?

A. It's my understanding that cigarettes pose significant health risks.

Q. All right. Well, that's all I'm saying to you.

A. Yeah.

Q. So we don't need to get into all this foolishness about the causation business. I mean, if you're exposed to the smoke that causes the risk, that's what the whole monitoring program is all about.

A. Well, that's clearly what the viability part of this case is, in large part, about.

Q. Okay. Yeah.

A. And that's not part of my charge.

Q. Right.

Now, and as I said, so that if you get over that hump, so now we're at the point of, okay, you know, then the judge is looking for help.

A. Then we have, as I appreciate it from the deposition, the fact that he has not done the crosswalk in regard to the monitoring program of multiple risk factors. I think we mentioned this briefly in the first deposition. But how many of these smokers, in fact, have the requisite second risk factor that would make them eligible for certain of these tests per his report. So that's another factor that's in there.

Q. Wait. Didn't he calculate that? I thought he did calculate that, actually. Didn't he calculate half?

A. Half of what?

Q. Half the population, half the smoking population. He used a .5.

A. Are you looking at a --

Q. I'm looking at his assumptions for

the screening program for the Scott class.

A. Uh-huh (indicating affirmatively).

Q. And he used a .5 instead of a 1 to acknowledge the fact that not everybody in the population is going to have other risk factors. That's why you see a .5 there under frequency per year.

A. Okay. I do not recall having seen that answer in the deposition transcript.

Q. Well, we went through all those numbers. The frequency numbers, for example, you see there's a 1 under "Spirometry"?

A. I'm sorry.

Q. I'm sorry. My fault. Let me just hand that to you. You see there's a 1 here (indicating)? You see there's a .5 under "Physical Exam"?

A. Well, that's frequency of testing per year.

Q. Right.

A. Uh-huh (indicating affirmatively). And this is once every two years, this is every year.

Q. But down here, when you get to be 45, I think it's every --

A. Forty-five plus for males, 55 for females, right. It's still every other year.

Q. Is it every other year? Okay. That's my mistake then. I thought it was -- I thought that's where he built that in right there.

A. But there could be something I'm not remembering in the deposition testimony.

Q. Okay.

A. The other issue that comes through in the deposition testimony, as I read it, is that there is still substantial debate as to the appropriateness of some of these tests, for example, in the bladder cancer screening area, which is medical opinion that --

Q. Which is not you?

A. Which is not me.

Q. You're not offering an opinion on that but, obviously, it would affect the cost?

A. It affects the cost.

Q. Well, sure.

A. And the appropriate ages and all those debates.

Q. Yeah. And we're not going there. I mean, that's --

A. Right.

Q. We agree that that's for others. I mean, --

A. Until those are settled questions, then it makes it impossible to calculate aggregate costs for the program.

Q. Well, but what we can agree on is that these numbers are easily calculated once you do know those answers? Because it's just a matter of math?

MR. STERN:

Well, let me object to the extent that Dr. Long has spoken to that quite a bit today. But subject to that.

MR. BRUNO:

I don't know what that means, but --

MR. STERN:

Well, you've asked that question and he's answered it. But go ahead.

EXAMINATION BY MR. BRUNO:

Q. I hadn't asked this question and that's why I'm asking it now. I want to make the point. Because you're making the point that the NMP-22 may or may not be included.

And it's crystal clear to all of us

that if it's not to be counted, then you easily just don't count it. But this whole business of the cost of a program is when you distill it, mathematics, the number of people times the participation rate plus the cost per service?

A. Right. Right.

Q. So it is a number that is very easily generated when these questions have been answered; right?

A. When you know the number of people, you know which tests, and you know at what age they get them, et cetera, then you get into the economics of the appropriate cost, which is what we're approaching here, including alternative ways of guaranteeing the services to the persons entitled to them.

Q. Right.

A. Which can be buy them on the open market, negotiate, make them yourself.

Q. Right.

A. And those have to be explored as appropriate, given the volumes. That's one of the things that hangs up the cost calculations and the estimates are that if you tell me that I actually only need this many (indicating) of

this service as opposed to this many
(indicating), it's going to change what I think
I can get them for per service.

Q. And that's exactly what Dr. Burns
testified to; isn't it?

A. He, indeed, acknowledged that
volume is an important factor --

Q. Right.

A. -- in deciding what per unit cost
you're going to be able to use. So it's more
than just arithmetic. Because depending on the
answers to those other questions will change
your cost numbers.

Q. But what he did say was that all of
these things may change, and that his proposal
was an exemplary program, and that the numbers
could be calculated? There wasn't this
business of it being impossible to do? It
simply was a matter of the Court or the jury or
whoever ultimately decides it indicating what
tests are going to be paid for and for what
ages, as you pointed out, and then the rest is
mathematics?

MR. STERN:

Objection to the form.

EXAMINATION BY MR. BRUNO:

Q. Isn't that true?

A. Well, I would point out that it's not just mathematics to determine the unit cost.

Q. It is mathematics once you've determined the unit cost because, as you point out --

A. Once you determine the unit cost.

Q. Yeah.

-- the larger the volume, the lower your cost per unit of service? And, indeed, the -- I'm sorry. The lower the volume, the higher the cost; the greater the volume, the lower the cost?

A. That, as a general proposition, is correct.

Returning to your previous question that we weren't quite finished with in terms of other things in the context of the deposition, of course, there was the change in the program related to, I gather, new standards or new information about the ability to read the scans and not requiring follow-ups.

But there was also the concern

which came to me from the reading that just as there had been lots of either mechanical or conceptual areas in the spreadsheets, many of which had to do with multiple years, which did not generate in me a high level of confidence in Dr. Burns' ability to manipulate spreadsheets, there was also this notion of where did these cost numbers come from?

And the one he had originally specifically been asked about, he attributed to Medicare. But Medicare has never paid that amount of money, to my knowledge, for a CT scan of any kind anywhere.

There's another place in his deposition, I believe, where he says, "Well, these were estimates of mine based on my experience that I sort of put out there for the Louisiana docs to give me feedback on." And maybe they did or maybe they didn't, depending on who you ask.

But, for example, spirometry, which is one of the numbers -- one of the prices, I think, $60 that was on a very early draft of a spreadsheet, the one, I think, from last April, that he said is just an estimate that he put

out there for discussion purposes. When I get to Volume III of his deposition, he says, you know, "That's a number that I think Dr. Ochsner gave me."

So I didn't come away with a sense that Dr. Burns had really done any cost investigation or cost analysis for this program, at least through the termination of his deposition; that he really hadn't figured out what Medicare or Medicaid paid for these things in Louisiana or anyplace else; that he hadn't looked at, you know, what could we produce the really high ticket items for as opposed to what we would have to pay in the open market. That he simply hadn't done a cost analysis at this point.

Q. Well, what did you find to be the costs? What was the cost of the physical exam?

A. The physical exam cost that we used was, I believe, $19.80 compared to $75.00.

Q. All right. And the cardiovascular screening with lipid subfractions?

A. The Medicare rate for that is $13.70. I'm sorry, the Medicare rate is $16.50. The Medicaid rate is $13.70.

Q. All right. How about spirometry?

A. Medicare, $35.79. Medicaid, $43.99.

Q. Cardiac exercise stress testing?

A. Medicare, $110.57. Medicaid, $88.91.

Q. All right. And, let's see, spiral CT?

A. Medicare, $289.52. Medicaid, $206.13.

And I would want to put in the record as a reminder that the Medicare rates I'm quoting are New Orleans, not outside of New Orleans, in Louisiana.

Q. All right. Urine test for hematuria?

A. That was the urinalysis. Medicare, $4.37. Medicaid, $3.71.

Q. All right. The NMP-22?

A. I could not find a Medicare or Medicaid rate, so I simply used Dr. Burns' in the absence of --

Q. It's 29.

A. -- being able to locate it, which was $29.

Q. Okay. And the urine cytology?

A. The urine cytology, the same as NMP-22. I was unable in the time I had to identify a separate code for that, so I used Dr. Burns' rate.

Q. Of 41?

A. Forty-one.

Q. Okay. All right. Any other criticisms of the method?

Actually, what I'm hearing you say is that in terms of the source of information, you think that the sources of his information may be inaccurate. But in terms of the methodology, it simply was multiplying it out? So you have no critique of that?

A. In terms of --

Q. Multiplying?

A. -- his arithmetic of number of people times this -- number of people at that age times this test costs, you know, if one took his cost, as nearly as I could tell, his arithmetic for the single year was okay.

Q. Okay. All right. So in pure terms of methodology, your method as would contrast his method is really not different? You've

just chosen to use the Medicare/Medicaid numbers versus his knowledge of what those numbers may be? I'm sorry. His knowledge of what those costs may be in the marketplace?

MR. STERN:

Well, let me just object to the form to the extent that Dr. Long testified that he used Dr. Burns' method. He just corrected the costs. But subject to that.

MR. BRUNO:

Okay. If you want to stipulate under Daubert that he's used the right methodology, I'm happy to do that.

MR. STERN:

No.

MR. BRUNO:

Which is what you just did.

MR. STERN:

No. I'm just saying that Dr. Long --

MR. BRUNO:

Well, you just did that.

MR. STERN:

No.

MR. BRUNO:

Yeah. I was trying to help you out here.

MR. STERN:

No, Joe.

MR. BRUNO:

Daubert is strictly methodology.

MR. STERN:

Joe, maybe you didn't listen to me.

MR. BRUNO:

I listened to you very carefully. You said he agreed with his methodology and he disagreed --

MR. STERN:

I didn't say agreed.

MR. BRUNO:

Well, what did you say then?

MR. STERN:

I said --

MR. BRUNO:

We can read it back. What does he say about methodology?

MR. STERN:

That he used his methodology, not that he agreed with it. He used Dr. Burns' approach. He just provided the

correct costs and made the corrections that Dr. Burns himself said he needed to make.

MR. BRUNO:

And I think we established the methodology was just math. And that he had no fault with the methodology.

Did I mis -- Did I not hear you?

MR. STERN:

Well, you have to define "methodology" if you --

MR. BRUNO:

No, I don't have to define "methodology." You've got to define "methodology."

MR. STERN:

Then I have to object to the form. I mean, does "methodology" include all these things we've been talking about all day?

MR. BRUNO:

Which is what I was asking about before you interrupted.

MR. STERN:

Go ahead, ask your question. I'll

just object to the form.

MR. BRUNO:

Well, I don't know what you're saying any more, Counselor. I mean, you've lost me completely.

EXAMINATION BY MR. BRUNO:

Q. But when it comes to the methodology, that is, the methodology employed to get from the cost per unit to the total, the math that Dr. Burns utilized was appropriate?

A. And now I'm confused. If you're asking me did he do his multiplication of "A" times "B" and get the correct product --

Q. Yes. Well, let's first establish -- Forget about him. The methodology that he employed, that is, multiplication, that was the correct methodology?

A. Well, that is hardly a description of his methodology. That is one mechanical step that he took. And the numbers that he put in, he multiplied together correctly --

Q. Right.

A. -- for that first year cost, as nearly as I can tell.

Q. Right.

A. Okay.

Q. And the next point, which is what I was alluding to, was that with regard to the selection of the costs per unit, all right, in terms of the methodology, your methodology and Burns' methodology are different because you chose to use the Medicare/Medicaid numbers; he chose to use his own assessment of what those services would cost? So there's a difference in methodology there?

A. Well, there is clearly a difference in methodology there. But I'm not sure that I would agree with your characterization of his methodology.

Q. Well, he'll be able to tell us what he meant. I mean, --

A. Well, he's told us two things in his deposition and I'm not sure which one --

Q. You say he told us two different things. And I disagree with that.

A. Okay.

Q. My point to you is, though, that when we first started this deposition, I asked you specifically what he based those numbers on. And I wrote it down. Your complaint was

that he used his own experience to get these numbers. Now, clearly --

A. That was in the cessation part.

Q. Right.

With regard to your numbers, you didn't choose to use your experience? You chose to go out and look at what Medicare or Medicaid utilized to reimburse for these services?

A. And in the case of one service, to purchase it.

Q. I understand.

But my point is that was a difference in methodology?

A. Yes, it is.

Q. That's all I'm saying.

All right. And you cannot say that it's inappropriate for a physician to utilize his own knowledge of what these services may cost in the marketplace; isn't that true?

A. I think there's a problem when he's wrong.

Q. Well, that's -- Wrong about what? You don't know if he's wrong.

A. Well, he said, for example, $328 is

a Medicare rate. It isn't.

Q. Well, that's not what I'm talking about. Because if he's reporting Medicare rates, then it's a matter of a mistake. And that the Medicare rate is the rate. As opposed to his utilizing his own knowledge of what these services cost. You can't say that that is an inappropriate way to determine the cost of services?

MR. STERN:

Object to the form.

A. If he, in fact, has that knowledge --

EXAMINATION BY MR. BRUNO:

Q. Right.

A. -- that would be an alternative approach.

Q. Yeah. And that's all I'm saying. I mean, I guess the distinction I'm making is that the guy says to you "I'm using Medicare rates" and he chose the wrong one, he made a mistake? But with regard to methodology, you do have the same methodology because you're using Medicare, he's using Medicare, he just plugged in the wrong number?

So there's not a problem with the methodology, there may have been a mistake in its application, but the methodology is good if both parties are using Medicare rates. You follow me? That's the only point I was trying to make.

A. Okay. And I would amend that in terms of my methodology. It's not simply saying, "Okay, I'm going to use Medicare rates." It's saying, "Let me look at real rates that are paid in high volume, dedicated programs for defined populations and see what they pay" as a point of departure.

Q. As an interesting question then, what did you do to determine real rates, that is, what hospitals charge for these various services? Did you check that out?

A. I did not. I can look at charge master listings. Understanding that nobody pays charges anymore, it's sort of an irrelevancy.

Q. Well, did you look to see what Tulane, for example, the institution where you are -- with which you are associated, what they charge for insurance reimbursements for these

same services?

A. I did not. But I happen to know that basically no commercial insurance companies or Blue Cross plans, et cetera, pay what Tulane puts on the patient bill, which is the charge. So even commercial insurance companies don't pay charges.

Q. I understand that.

I didn't ask that. I said what Tulane gets paid from these providers. In other words, the actual dollars that change hands --

A. No, I did not.

Q. -- between Tulane and --

A. The answer to your question is I did not.

Q. Yeah. I mean, that's all I'm saying.

All right. But the bottom line is with regard to the provision of services, okay, as a method, all these methods are good as long as you are finding out, in fact, what the provider is getting paid and what the willing payer is willing to pay?

A. For a defined service and volume.

Q. Right, for a defined service.

A. Yes. Right.

Q. I mean, you don't want to pay a number that you and I just made up and you don't want to pay a number that's not going to at least reimburse for the cost of the services in the first place? You've got to go see what the market has to say about it?

A. Yes.

MR. BRUNO:

All right. Okay. It must be 5:00 o'clock. It is 5:00 o'clock. All right. I got to go. Let me see.

I think I've got it all covered but I just, because I have to go now, I guess if I have to get more time, I'll just fight with counsel about it and not mess with you.

THE WITNESS:

Thank you.

MR. BRUNO:

All right. Because I'm pretty sure I got it covered. But I, in view of the hour, I don't know that I have. But we'll work it out. Okay?

MR. STERN:

Joe, I appreciate what you're saying. Let me just state for the record, we're --

MR. BRUNO:

It's for the record, I understand.

MR. STERN:

-- we would keep going if you wanted to, but --

MR. BRUNO:

I understand. But I can't.

MR. STERN:

Okay.

MR. BRUNO:

And, you know, when we were doing Dr. Burns, your boy couldn't keep going. And I can give you five or six other depositions where they couldn't keep going.

I can give you my favorite example which is at 2:00 o'clock the guy says he's got one more question and at 5:20 he's still going. I got an airplane at 5:35, which I made in about two seconds.

So I appreciate the sentiment but it

just goes way over my head. All right.

THE VIDEOGRAPHER:

Going off the record at 5:05.

(Whereupon the deposition was concluded at 5:05 o'clock p.m.)

* * * * *

WITNESS' CERTIFICATE

I have read or have had the foregoing testimony read to me and hereby certify that it is a true and correct transcription of my testimony, with the exception of any attached corrections or changes.

HUGH W. LONG, Ph.D.

REPORTER'S CERTIFICATE

I, CHERYL FOURNET HUFFMAN, Registered Merit Reporter, in and for the State of Louisiana, as the officer before whom this testimony was taken, do hereby certify that HUGH W. LONG, Ph.D., after having been duly sworn by me upon authority of R.S. 37:2554, did testify as hereinbefore set forth in the foregoing 200 pages; that this testimony was reported by me in the stenotype reporting method, was prepared and transcribed by me or under my personal direction and supervision, and is a true and correct transcript to the best of my ability and understanding; that I am not related to counsel or to the parties herein, nor am I otherwise interested in the outcome of this matter.

Cheryl F. Huffman

CHERYL FOURNET HUFFMAN, RMR, CRR
Registered Merit Reporter
Certified Realtime Reporter
(No. 75009)
Huffman & Robinson, Inc.
One Shell Square, Suite 250 Annex
New Orleans, Louisiana 70139
(504) 525-1753 (800) 749-1753

ADAMS AND REESE LLP

Attorneys at Law
Baton Rouge
Houston
Jackson
Mobile
New Orleans
Washington, DC

Martin A. Stern
Also admitted in
the District of Columbia
(504) 585-0289
sternma@arlaw.com

5 April 2001

VIA HAND DELIVERY

Robert L. Redfearn, Sr., Esq.
Plaintiffs' Liaison Counsel
SIMON, PERAGINE, SMITH & REDFEARN
1100 Poydras
Energy Centre, Suite 3000
New Orleans, LA 70163

Re: Gloria Scott, et al. v. The American Tobacco Company, et al.

Dear Bob:

Enclosed please find spreadsheets generated by Hugh Long, Ph.D. that are responsive to Dr. Burns' recent deposition testimony. We are also including electronic copies on the enclosed disk as well as Dr. Long's sources for the spreadsheets. In providing these, neither Defendants nor Dr. Long should be seen as accepting Dr. Burns' proposed medical monitoring program or setting forth any amount of damages that should be awarded in the event of a liability finding. On the contrary, Defendants' position is that the cost of the monitoring program is impossible to predict, in part because the identity of class members cannot even be determined.

The purpose of the spreadsheets, therefore, is only to show that even within Dr. Burns' own framework, the cost of the proposed monitoring program is much lower than that estimated by Dr. Burns. Thus, Dr. Long does not correct any of the many problems with Dr. Burns' approach that Defendants have set forth in various motions, including in the Daubert/Foret motion directed at Dr. Burns' testimony. Just for example, Dr. Long's spreadsheets do not address the fact that Dr. Burns' proposed program (1) assumes a participation rate that is far too high and which is impossible to predict; (2) would provide monitoring to class members who have not smoked enough to warrant any monitoring; (3) would provide monitoring to class members who have not shown that they were caused to smoke because of any allegedly tortious conduct on Defendants' part; and (4) would provide monitoring that does not meet the Bourgeois factors,

Adams and Reese, L.L.P.

including, for example, spiral CT scans, even though every major public health organization has taken a position against using this procedure to monitor any segment of the population.

Rather than attempting to correct any of these problems, Dr. Long addresses Dr. Burns' estimate based on purchasing the proposed procedures. Thus, Dr. Long changes only those assumptions in Dr. Burns' spreadsheets that Dr. Burns has himself corrected or clarified in his very recent deposition. Accordingly, the cost of the proposed procedures is based on what Medicare and Medicaid charge because Dr. Burns testified that it was appropriate to look to these sources. Second, there is no charge for a follow-up CT scan because Dr. Burns testified that a follow-up CT scan is now unnecessary. Third, Dr. Long runs the spreadsheets not only with the 100% participation rate that Dr. Burns testified he was ultimately instructed to use by Plaintiffs' counsel, but also with a 35% participation rate that Dr. Burns testified that he himself felt was realistic. Then, after checking Dr. Burns estimate based on purchasing the proposed procedures, Dr. Long sets forth an alternative approach that, with respect to spiral CT scans only, is based on the cost of purchasing and running the required CT scanning machines.

We are furnishing the spreadsheets to Plaintiffs now so that you have them in ample time to prepare for the completion of Dr. Long's deposition, which is scheduled nearly two weeks from now on April 17, 2001.

Very truly yours,
ADAMS AND REESE LLP

MARTIN A. STERN

MAS/meb
Enclosures
cc: Mr. Joe Bruno (w/spreadsheet enclosure) via fax
Ms. Suzanne Foulds (w/spreadsheet enclosure) via fax
Mr. Dominic Gianna, Special Master (w/spreadsheet enclosure) via fax
All Defense Counsel (w/spreadsheet enclosure) via fax

Budget Assumptions For a Statewide Cessation Program for Louisiana

Number of Daily smokers	Method	% of quit attempts using method	Number of quit attempts	Current Real World Additional Effectiveness	Number of long term quits	Potential fraction of quit attempts using method	Potential effectiveness	Potential Quits	Cost of Service	Cost of Delivery	Cost per Increased Quit	Fraction of Class Participating	Program Costs
658,138	Self	0.33	217,185	0.04	8,687	1.00	0.04	13,163	50.00	$10,859,271	$2,426	1.00	$10,859,271
	Pharmacological Treatment	0.30	65,156	0.02	1,303	0.80	0.05	9,872	100.00	$13,031,126	$1,521	0.50	$6,515,563
	Telephone counseling	0.00	658	0.05	33	0.25	0.05	4,113	150.00	$8,144,454	$1,986	1.00	$8,144,454
	Health System Interventions	0.40	86,874	0.01	869	0.70	0.05	11,517	25.00	$3,800,745	$357	1.00	$3,800,745
	Clinic	0.03	5,430	0.30	1,629	0.02	0.30	1,974	500.00	$2,171,854	$6,286	0.50	$1,085,927
	Total	0.33	217,185 Total Quits		12,521	0.50 Total Quits		40,640	Total Cost	$38,007,450			$30,405,960
				Fraction Quitting	0.019		Fraction Quitting	0.062					

CURRENT

POTENTIAL

Program Year	Number of Daily Smokers age 18 and older in Louisiana with current rate of decline	Number of Daily Smokers in Louisiana age 18 and older with new rate of decline	COST
1	658,138	658,138	$30,405,960
2	645,617	617,498	$28,527,467
3	633,334	579,367	$28,260,019
4	621,286	543,591	$28,703,247
5	609,465	510,024	$28,157,268
6	597,870	478,530	$27,621,574
7	586,495	448,981	$27,096,073
8	575,337	421,257	$26,580,570
9	564,391	395,244	$26,074,875
10	553,654	370,838	$25,578,800
11	543,120	347,908	$25,092,164
12	532,784	326,453	$24,614,785
13	522,651	306,295	$24,146,468
14	512,708	287,381	$23,687,102
15	502,954	269,635	$23,236,455
16	493,385	252,985	$22,794,381
17	483,998	237,363	$22,360,718
18	474,790	222,706	$21,935,308
19	465,757	208,954	$21,517,987
20	456,896	196,051	$21,108,607
21	448,204	183,945	$20,707,018
22	439,677	172,586	$20,313,085
23	431,312	161,929	$19,926,679
24	423,108	151,930	$19,547,676
25	415,057	142,548	$19,175,960

$609,469,771

LONG
EXHIBIT NO. 4
HUFFMAN & ROBINSON, INC.
COURT REPORTERS

52434 8067

LGNG
EXHIBIT NO. 5
HUFFMAN & ROBINSON, INC.
COURT REPORTERS

PURCHASING MONITORING SERVICES--One-Year Projection (35% Participation Rate)

Estimated Class Size Per Dr. Burns:	
25-39	420,567
Age 40	31,392
Male 45+ (under 75)	351,050
Female 55+ (under 75)	126,550
50+ (under 75)	434,951

	Age Group	Cost/ Test	Freq. of Testing/ Year	Fraction of Population Participation	Total Cost per Test per Class Member	Total Year 1 Cost Using # in Class Per Estimate of Dr. Burns
Physical Exam						
Price Per D. Burns	25-39	75.00	0.50	0.35	13.13	5,519,942
Price Per LA Medicaid	25-39	19.80	0.50	0.35	3.47	1,457,265
Price Per Medicare (N/C, used 'Caid)	25-39	19.80	0.50	0.35	3.47	1,457,265
Lipids						
Price Per D. Burns	25-39	25.00	1.00	0.35	8.75	3,679,961
Price Per LA Medicaid	25-39	13.70	1.00	0.35	4.80	2,016,619
Price Per Medicare	25-39	16.50	1.00	0.35	5.78	2,428,774
Spirometry						
Price Per D. Burns	40	60.00	1.00	0.35	21.00	659,232
Price Per LA Medicaid	40	43.99	1.00	0.35	15.40	483,327
Price Per Medicare	40	35.79	1.00	0.35	12.53	393,232
Cardiac Stress Test						
Price Per D. Burns	Male 45+	350.00	0.50	0.18	30.63	10,750,906
Price Per LA Medicaid	Male 45+	88.91	0.50	0.18	7.78	2,731,037
Price Per Medicare	Male 45+	110.57	0.50	0.18	9.67	3,396,365
Cardiac Stress Test						
Price Per D. Burns	Female 55+	350.00	0.50	0.18	30.63	13,320,374
Price Per LA Medicaid	Female 55+	88.91	0.50	0.18	7.78	3,383,756
Price Per Medicare	Female 55+	110.57	0.50	0.18	9.67	4,208,097

PURCHASING MONITORING SERVICES (35% Participation Rate–continued)

		Age Group	Cost/ Test	Freq. of Testing/ Year	Fraction of Population Participation	Total Cost per Test per Class Member	Total Year 1 Cost Using # in Class Per Estimate of Dr. Burns
Physical Exam							
	Price Per D. Burns	Male 45+	75.00	0.50	0.18	6.56	2,303,766
	Price Per LA Medicaid	Male 45+	19.80	0.50	0.18	1.73	608,194
	Price Per Medicare	Male 45+	19.80	0.50	0.18	1.73	608,194
Physical Exam							
	Price Per D. Burns	Female 55+	75.00	0.50	0.18	6.56	830,484
	Price Per LA Medicaid	Female 55+	19.80	0.50	0.18	1.73	219,248
	Price Per Medicare	Female 55+	19.80	0.50	0.18	1.73	219,248
Spirometry							
	Price Per D. Burns	50+	60.00	0.20	0.35	4.20	1,826,794
	Price Per LA Medicaid	50+	43.99	0.20	0.35	3.08	1,339,345
	Price Per Medicare	50+	35.79	0.20	0.35	2.51	1,089,683
Urinalysis							
	Price Per D. Burns	50+	5.00	1.00	0.35	1.75	761,164
	Price Per LA Medicaid	50+	3.71	1.00	0.35	1.30	564,784
	Price Per Medicare	50+	4.37	1.00	0.35	1.53	665,258
Spiral CT Scan							
	Price Per D. Burns	50+	328.00	1.00	0.35	114.80	49,932,375
	Price Per LA Medicaid	50+	206.13	1.00	0.35	72.15	31,379,757
	Price Per Medicare	50+	289.52	1.00	0.35	101.33	44,074,455
NMP22							
	Price Per D. Burns	50+	29.00	1.00	0.35	10.15	4,414,753
Urine Cytology							
	Price Per D. Burns	50+	41.00	1.00	0.35	14.35	6,241,547

.UMMARY OF COSTS OF MONITORING @ MEDICARE AND MEDICAID RATES (35% Participation Rate)

'otal Year One Monitoring Costs Using · Dr. Burns's Class Size Estimates	@ LA 'Caid Rates	@ M'Care Rates
;T Scans Purchased Scan by Scan	31,379,757	44,074,455
'hysical Exam	2,284,707	2,284,707
.ipids	2,016,619	2,428,774
;ardiac Stress Test	6,114,793	7,604,461
;pirometry	1,822,672	1,482,915
Jrinalysis	564,784	665,258
VMP22 Using Dr. Burns's Rate	4,414,753	4,414,753
Jrine Cytology Using Dr. Burns's Rate	6,241,547	6,241,547
'rogram Administrative Costs	1,645,189	1,383,937
TOTAL MONITORING COSTS	56,484,820	70,580,806
Cost of CT Scans as Purchased Services	31,379,757	44,074,455
TOTAL MONITORING COSTS NET OF CTs	25,105,062	26,506,352

52434 8069

CT SCANNER PURCHASE OPTION--One-Year Projection (35% Participation Rate)

Assumptions/Base Calculations:

LA 50+ Population per Dr. Burns	434,951
Spiral CT Scans/Person 50+/Year	1
Assumed Participation Rate (Dr. Burns Draft and Deposition)	35%
Spiral CT Scans/Year	152,233
Scanner Hours of Operation	
Monday through Friday 7a to 7p	60
Saturday 7a to 2p	7
Total Hours of Operation/Week	67
Operational Weeks/Year	50
Annual Hours of Operation	3350
Scanner Capacity for Screening CT: Scans per hour at:	
Minimum Capacity	4
Mid-Range Capacity	5
Maximum Capacity	6
Annual Capacity Per Scanner	
Minimum Capacity	13,400
Mid-Range Capacity	16,750
Maximum Capacity	20,100

Number of Locations Needed by State Planning District Based on Population	Capacity Minimum	Capacity Mid-Range	Capacity Maximum
SPD1	2	2	1
SPD2	1	1	1
SPD3	1	1	1
SPD4	1	1	1
SPD5	1	1	1
SPD6	1	1	1
SPD7	1	1	1
SPD8	1	1	1
Total Locations	9	9	8

52434 8070

GEOGRAPHIC DISTRIBUTION OF SCANS (35% Participation Rate)

52434 8071

		SPD 1	SPD 2	SPD 3	SPD 4	SPD 5	SPD 6	SPD 7	SPD 8	Tot
% of Total State Population		27.5%	18.8%	7.5%	13.5%	6.3%	6.8%	12.5%	7.1%	100.0
50+ Population in Class (Dr. Burns):	152,233									
Pro-Rata Distribution of 50+ across SPDs		41,864	28,620	11,417	20,551	9,591	10,352	19,029	10,809	152,23
Number of CT Scanners Needed Operating at Minimum Capacity:										
Population Driven Capacity Needs:		3.1242	2.1358	0.8520	1.5337	0.7157	0.7725	1.4201	0.8066	11.360
# of Scanners Needed:		4	2	1	2	1	1	2	1	1
Number of CT Scanners Needed Operating at Mid-Range Capacity:										
Population Driven Capacity Needs:		2.4993	1.7086	0.6816	1.2270	0.5726	0.6180	1.1361	0.6453	9.088
# of Scanners Needed:		3	2	1	2	1	1	2	1	1
Number of CT Scanners Needed Operating at Maximum Capacity:										
Population Driven Capacity Needs:		2.0828	1.4239	0.5680	1.0225	0.4771	0.5150	0.9467	0.5377	7.573
# of Scanners Needed:		3	2	1	2	1	1	1	1	1

Number of CT Scanners Needed to Deliver Required Number of Scans

Capacity:	Minimum	Mid-Range	Maximum
	14	13	12

CT SCANNER PURCHASE OPTION (35% Participation Rate)

Number of CT Scanners Purchased If Operating At:			
Minimum Capacity	14		
Mid-Range Capacity	13		
Maximum Capacity	12		
Number of CT Scans In Year 1	152,233		
Acquisition Cost of CT Scanner (Including Installation & Maintenance)	$500,000	$750,000	$1,000,000
Total Cost of Scanners Based on:			
Minimum Capacity	7,000,000	10,500,000	14,000,000
Mid-Range Capacity	6,500,000	9,750,000	13,000,000
Maximum Capacity	6,000,000	9,000,000	12,000,000
Scanner Operating Hours Per Year	3,350		
Effective Hours of One Full-Time-Equivalent Employed Person (FTE)		Weeks	Hours/Week
Gross Hours Per Year	2,080	52	40
Less Estimated Time for Vacation, Holidays, Personal Time	168		
Net Hours Per Year	1,912		
FTEs Required to Fill One Staff Position Per Scanner	1.76		
Technologists			
- Average Annual Salary of:	$41,030		
-Benefits as a % of Annual Salary:			
25.0%	8,732		
Total Compensation Per Technologist	53,660		
Number of Technologists Per Scanner	1.76		
Minimum Capacity	1,035,048		
Mid-Range Capacity	994,452		
Maximum Capacity	937,958		
Clerical Workers			
- Average Annual Salary of:	$19,831		
- Benefits as a % of Annual Salary:			
25.0%	4,958		
Total Compensation Per Clerical Worker	24,789		
Number of Clerical Workers Per Scanner	1.76		
Total Cost of Clerical Workers			
Minimum Capacity	610,503		
Mid-Range Capacity	586,496		
Maximum Capacity	553,289		
Radiologist			
-Estimated Number of Images Reviewed Per Year Per Radiologist	11,600		
-Estimated Number of Images To Be Reviewed Per Year	152,233		
-Number of Radiologists Needed	13.12		
-Average Radiologist Total Compensation (including bonus & incentives)	254,279		
Total Compensation for Radiologists	3,337,036		

Lease Space All Sites	Minimum	Mid-Range	Maximum	
Number of Locations	9	9	8	
Estimated Sq. Ft./Location	3,000	3,000	3,000	
Average Lease Rate/Sq. Ft./Year	10.46	10.46	10.46	
Estimated Total Lease Expense	282,420	282,420	251,040	
Other Occupancy Expense All Sites				Per Site/Per Year
Estimated Utilities & Telephone/Year	108,000	108,000	96,000	12,000
Estimated Property Insurance/Year	36,000	36,000	32,000	4,000
Estimated Office Expense/Year	108,000	108,000	96,000	12,000
Estimated Other Occupancy Expense/Year	252,000	252,000	224,000	
Total Operating Expenses				
Minimum Capacity	5,552,906			
Mid-Range Capacity	5,432,604			

CT Scanner Purchase Option: Summary (35% Participation Rate)

Acquisiton Cost Per Scanner	$500,000		$750,000		$1,000,000	
Equipment Purchase Cost Loaded into One Year of Activity	Total	Per Scan	Total	Per Scan	Total	Per Scan
Minimum Capacity	7,000,000	$45.98	10,500,000	$68.97	14,000,000	$91.96
Mid-Range Capacity	6,500,000	42.70	9,750,000	64.05	13,000,000	85.40
Maximum Capacity	6,000,000	39.41	9,000,000	59.12	12,000,000	78.83
Operating Expenses						
Minimum Capacity	5,552,908	36.48	5,552,908	36.48	5,552,908	36.48
Mid-Range Capacity	5,432,804	35.69	5,432,804	35.69	5,432,804	35.69
Maximum Capacity	5,253,321	34.51	5,253,321	34.51	5,253,321	34.51
Total Costs						
Minimum Capacity	12,552,908	82.46	16,052,908	105.45	19,552,908	128.44
Mid-Range Capacity	11,932,804	78.39	15,182,804	99.73	18,432,804	121.08
Maximum Capacity	11,253,321	73.92	14,253,321	93.63	17,253,321	113.34
TOTAL MONITORING COSTS USING PURCHASED SERVICES NET OF CTs						
@Medicare Rates	26,506,352		26,506,352		26,506,352	
@Medicaid Rates	25,105,062		25,105,062		25,105,062	
TOTAL MONITORING COSTS WITH CT SCANS PROVIDED BY PURCHASED CT SCANNERS AND REMAINDER OF SERVICES PURCHASED AT:						
MEDICARE RATES						
Minimum Capacity	39,059,260		42,559,260		46,059,260	
Mid-Range Capacity	38,439,156		41,689,156		44,939,156	
Maximum Capacity	37,759,672		40,759,672		43,759,672	
MEDICAID RATES						
Minimum Capacity	37,657,970		41,157,970		44,657,970	
Mid-Range Capacity	37,037,867		40,287,867		43,537,867	
Maximum Capacity	36,358,383		39,358,383		42,358,383	

PURCHASING MONITORING SERVICES--One-Year Projection (100% Participation Rate)

52434 8074

LONG
EXHIBIT NO. 6
HUFFMAN & ROBINSON, INC.
COURT REPORTERS

Estimated Class Size Per Dr. Burns:

25-39	420,567
Age 40	31,392
Male 45+ (under 75)	351,050
Female 55+ (under 75)	126,550
50+ (under 75)	434,951

	Age Group	Cost/ Test	Freq. of Testing/ Year	Fraction of Population Participation	Total Cost per Test per Class Member	Total Year 1 Cost Using # in Class Per Estimate of Dr. Burns
Physical Exam						
Price Per D. Burns	25-39	75.00	0.50	1.00	37.50	15,771,263
Price Per LA Medicaid	25-39	19.80	0.50	1.00	9.90	4,163,613
Price Per Medicare (N/C, used 'Caid)	25-39	19.80	0.50	1.00	9.90	4,163,613
Lipids						
Price Per D. Burns	25-39	25.00	1.00	1.00	25.00	10,514,175
Price Per LA Medicaid	25-39	13.70	1.00	1.00	13.70	5,761,768
Price Per Medicare	25-39	16.50	1.00	1.00	16.50	6,939,356
Spirometry						
Price Per D. Burns	40	60.00	1.00	1.00	60.00	1,883,520
Price Per LA Medicaid	40	43.99	1.00	1.00	43.99	1,380,934
Price Per Medicare	40	35.79	1.00	1.00	35.79	1,123,520
Cardiac Stress Test						
Price Per D. Burns	Male 45+	350.00	0.50	0.50	87.50	30,716,875
Price Per LA Medicaid	Male 45+	88.91	0.50	0.50	22.23	7,802,964
Price Per Medicare	Male 45+	110.57	0.50	0.50	27.64	9,703,900
Cardiac Stress Test						
Price Per D. Burns	Female 55+	350.00	0.50	0.50	87.50	38,058,213
Price Per LA Medicaid	Female 55+	88.91	0.50	0.50	22.23	9,667,873
Price Per Medicare	Female 55+	110.57	0.50	0.50	27.64	12,023,133

PURCHASING MONITORING SERVICES (100% Participation Rate--continued)

52434 8075

		Age Group	Cost/ Test	Freq. of Testing/ Year	Fraction of Population Participation	Total Cost per Test per Class Member	Total Year 1 Cost Using # in Class Per Estimate of Dr. Burns
Physical Exam							
	Price Per D. Burns	Male 45+	75.00	0.50	0.50	18.75	6,582,188
	Price Per LA Medicaid	Male 45+	19.80	0.50	0.50	4.95	1,737,698
	Price Per Medicare	Male 45+	19.80	0.50	0.50	4.95	1,737,698
Physical Exam							
	Price Per D. Burns	Female 55+	75.00	0.50	0.50	18.75	2,372,813
	Price Per LA Medicaid	Female 55+	19.80	0.50	0.50	4.95	626,423
	Price Per Medicare	Female 55+	19.80	0.50	0.50	4.95	626,423
Spirometry							
	Price Per D. Burns	50+	60.00	0.20	1.00	12.00	5,219,412
	Price Per LA Medicaid	50+	43.99	0.20	1.00	8.80	3,826,699
	Price Per Medicare	50+	35.79	0.20	1.00	7.16	3,113,379
Urinalysis							
	Price Per D. Burns	50+	5.00	1.00	1.00	5.00	2,174,755
	Price Per LA Medicaid	50+	3.71	1.00	1.00	3.71	1,613,668
	Price Per Medicare	50+	4.37	1.00	1.00	4.37	1,900,736
Spiral CT Scan							
	Price Per D. Burns	50+	328.00	1.00	1.00	328.00	142,663,928
	Price Per LA Medicaid	50+	206.13	1.00	1.00	206.13	89,656,450
	Price Per Medicare	50+	289.52	1.00	1.00	289.52	125,927,014
NMP22							
	Price Per D. Burns	50+	29.00	1.00	1.00	29.00	12,613,579
Urine Cytology							
	Price Per D. Burns	50+	41.00	1.00	1.00	41.00	17,832,991

ıMMARY OF COSTS OF MONITORING @ MEDICARE AND MEDICAID RATES (100% Participation Rate)

tal Year One Monitoring Costs Using Dr. Burns's Class Size Estimates	@ LA 'Caid Rates	@ M'Care Rates
' Scans Purchased Scan by Scan	89,656,450	125,927,014
ysical Exam	6,527,733	6,527,733
ılds	5,761,768	6,939,356
ırdiac Stress Test	17,470,837	21,727,033
·irometry	5,207,633	4,236,899
Inalysis	1,613,668	1,900,736
ΛP22 Using Dr. Burns's Rate	12,613,579	12,613,579
Ine Cytology Using Dr. Burns's Rate	17,832,991	17,832,991
ɔgram Administrative Costs	4,700,540	3,954,107
)TAL MONITORING COSTS	161,385,199	201,659,447
ıst of CT Scans as Purchased Services	89,656,450	125,927,014
)TAL MONITORING COSTS NET OF CTs	71,728,749	75,732,433

T SCANNER PURCHASE OPTION--One-Year Projection (100% Participation Rate)

ssumptions/Base Calculations:

A 50+ Population per Dr. Burns	434,951
piral CT Scans/Person 50+/Year	1
ssumed Participation Rate (Dr. Burns Most Recent Report)	100%
piral CT Scans/Year	434,951
canner Hours of Operation	
Monday through Friday 7a to 7p	60
Saturday 7a to 2p	7
otal Hours of Operation/Week	67
)perational Weeks/Year	50
.nnual Hours of Operation	3350
canner Capacity for Screening CT:	
Scans per hour at:	
Minimum Capacity	4
Mid-Range Capacity	5
Maximum Capacity	6
.nnual Capacity Per Scanner:	
Minimum Capacity	13,400
Mid-Range Capacity	16,750
Maximum Capacity	20,100

lumber of Locations Needed by State Planning District Based on Population		Capacity		
		Minimum	Mid-Range	Maximum
	SPD1	5	4	3
	SPD2	3	3	2
	SPD3	1	1	1
	SPD4	2	2	2
	SPD5	1	1	1
	SPD6	1	1	1
	SPD7	2	1	2
	SPD8	1	1	1
	Total Locations	16	14	13

GEOGRAPHIC DISTRIBUTION OF SCANS (100% Participation Rate)

		SPD 1	SPD 2	SPD 3	SPD 4	SPD 5	SPD 6	SPD 7	SPD
% of Total State Population		27.5%	18.8%	7.5%	13.5%	6.3%	6.8%	12.5%	7.1
50+ Population in Class (Dr. Burns):	434,951								
Pro-Rata Distribution of 50+ across SPDs		119,612	81,771	32,621	58,718	27,402	29,577	54,369	30,8
Number of CT Scanners Needed Operating at Minimum Capacity:									
Population Driven Capacity Needs:		8.9262	6.1023	2.4344	4.3820	2.0449	2.2072	4.0574	2.30
# of Scanners Needed:		9	7	2	5	2	2	5	
Number of CT Scanners Needed Operating at Mid-Range Capacity:									
Population Driven Capacity Needs:		7.1410	4.8818	1.9475	3.5056	1.6359	1.7658	3.2459	1.84
# of Scanners Needed:		8	5	2	4	2	2	3	
Number of CT Scanners Needed Operating at Maximum Capacity:									
Population Driven Capacity Needs:		5.9508	4.0682	1.6230	2.9213	1.3633	1.4715	2.7049	1.53
# of Scanners Needed:		6	4	2	3	1	2	3	

Number of CT Scanners Needed to Deliver Required Number of Scans

Capacity:	Minimum	Mid-Range	Maximum
	34	28	23

T SCANNER PURCHASE OPTION (100% Participation Rate)

Number of CT Scanners Purchased If Operating At:			
Minimum Capacity	34		
Mid-Range Capacity	28		
Maximum Capacity	23		
Number of CT Scans In Year 1	434,951		
Acquisition Cost of CT Scanner (Including Installation & Maintenance)	$500,000	$750,000	$1,000,000
Total Cost of Scanners Based on:			
Minimum Capacity	17,000,000	25,500,000	34,000,000
Mid-Range Capacity	14,000,000	21,000,000	28,000,000
Maximum Capacity	11,500,000	17,250,000	23,000,000
Scanner Operating Hours Per Year	3,350		
Effective Hours of One Full Time-Equivalent Employed Person (FTE)		Weeks	Hours/Week
Gross Hours Per Year	2,080	52	40
Less Estimated Time for Vacation, Holidays, Personal Time	-168		
Net Hours Per Year	1912		
FTEs Required to Fill One Staff Position Per Scanner	1.75		
Technologists			
- Average Annual Salary of:	34,928		
-Benefits as a % of Annual Salary:			
25.0%	8,732		
Total Compensation Per Technologist	43,660		
Number of Technologists Per Scanner	1.75		
Minimum Capacity	2,600,878		
Mid-Range Capacity	2,141,897		
Maximum Capacity	1,756,416		
Clerical Workers			
- Average Annual Salary of	19,813		
- Benefits as a % of Annual Salary:			
25.0%	4,978		
Total Compensation Per Clerical Worker	24,820		
Number of Clerical Workers Per Scanner	1.75		
Total Cost of Clerical Workers			
Minimum Capacity	1,482,651		
Mid-Range Capacity	1,221,207		
Maximum Capacity	1,002,970		
Radiologist			
-Estimated Number of Images Reviewed Per Year Per Radiologist	11,600		
-Estimated Number of Images To Be Reviewed Per Year	434,951		
-Number of Radiologists Needed	37.50		
-Average Radiologist Total Compensation (Including Bonus & Incentives)	254,279		
Total Compensation for Radiologists	9,534,388		

Lease Space All Sites	Minimum	Mid-Range	Maximum
Number of Locations	16	14	13
Estimated Sq. Ft./Location	3,000	3,000	3,000
Average Lease Rate/Sq. Ft./Year	10.46	10.46	10.46
Estimated Total Lease Expense	502,080	439,320	407,940

Other Occupancy Expense All Sites				Per Site/Per Year
Estimated Utilities & Telephone/Year	192,000	168,000	156,000	12,000
Estimated Property Insurance/Year	64,000	56,000	52,000	4,000
Estimated Office Expense/Year	192,000	168,000	156,000	12,000
Estimated Other Occupancy Expense/Year	448,000	392,000	364,000	

Total Operating Expenses	
Minimum Capacity	14,567,995
Mid-Range Capacity	13,726,613

52434 8079

CT Scanner Purchase Option: Summary (100% Participation Rate)

Acquisiton Cost Per Scanner	$500,000		$750,000		$1,000,000	
Equipment Purchase Cost Loaded into One Year of Activity	Total	Per Scan	Total	Per Scan	Total	Per Scan
Minimum Capacity	17,000,000	$39.08	25,500,000	$58.63	34,000,000	$78.17
Mid-Range Capacity	14,000,000	32.19	21,000,000	48.28	28,000,000	64.38
Maximum Capacity	11,500,000	26.44	17,250,000	39.66	23,000,000	52.88
Operating Expenses						
Minimum Capacity	14,567,995	33.49	14,567,995	33.49	14,567,995	33.49
Mid-Range Capacity	13,728,613	31.56	13,728,613	31.56	13,728,613	31.56
Maximum Capacity	13,068,714	30.05	13,068,714	30.05	13,068,714	30.05
Total Costs						
Minimum Capacity	31,567,995	72.58	40,067,995	92.12	48,567,995	111.66
Mid-Range Capacity	27,728,613	63.75	34,728,613	79.84	41,728,613	95.94
Maximum Capacity	24,568,714	56.49	30,318,714	69.71	36,068,714	82.93
TOTAL MONITORING COSTS USING PURCHASED SERVICES NET OF CTs						
@Medicare Rates	75,732,433		75,732,433		75,732,433	
@Medicaid Rates	71,728,749		71,728,749		71,728,749	
TOTAL MONITORING COSTS WITH CT SCANS PROVIDED BY PURCHASED CT SCANNERS AND REMAINDER OF SERVICES PURCHASED AT:						
MEDICARE RATES						
Minimum Capacity	107,300,428		115,800,428		124,300,428	
Mid-Range Capacity	103,461,046		110,461,046		117,461,046	
Maximum Capacity	100,301,147		106,051,147		111,801,147	
MEDICAID RATES						
Minimum Capacity	103,296,744		111,796,744		120,296,744	
Mid-Range Capacity	99,457,362		106,457,362		113,457,362	
[illegible]	96,297,463		102,047,463		107,797,463	

52434 8080

SCOTT CASE

Listing of sources used to prepare Cost of Monitoring Program spreadsheet:

1. Louisiana Department of Labor Internet site regarding state planning districts:

   www.ldol.state.la.us/forms/lml/geograph.doc

2. "Cost of screening CT" slide presentation:

   http://icscreen.med.cornell.edu/2CP/Clark/

3. State of Louisiana Department of Health and Hospitals, Office of Management & Finance, Bureau of Health Services Financing Memorandum of August 22, 2000 with enclosed Medicaid fee schedule

4. Medicare Part B Carrier for Louisiana, Reasonable Charges and Customer Service Sections

5. For Louisiana parish population estimates–

   LEAP (Louisiana Electronic Assistance Program) Center for Business & Economic Research University of Louisiana at Monroe

   http://leap.nlu.edu/POPHS/pop1999.txt

6. Various press releases relating to pricing of CT scanners

7. Radiology Tech, clerical worker, and radiologist compensation information from salary.com

8. Property lease rates obtained from internet search of Louisiana properties

9. Information from radiology list serve AHRAlist

10. "U.S. Radiologists' Workload In 1995-1996 and Trends since 1991-1992," *Radiology*, 1998 Jul:208(1):19-24

11. Verification on Medicare payment rates for medical procedures delivered at freestanding facilities on federal government websites:

http://www.hcfa.gov/stats/pufiles.htm#carrpuf

http://www.access.gov.gpo.gov/su_docs/fedreg/